



Idaho Falls Pediatrics

2375 Coronado St., Idaho Falls, ID 83404

1645 Pancheri Dr., Idaho Falls, ID 83402



Ron Porter MD • Scott Smith DO • Joseph Moore MD • Mitchael Steorts MD • Travis Christensen PA-C • Samantha Lange PA-C
(208) 522-4600 • Fax: (208) 552-7521

Medical Record Release

Authorization to release medical information and/or medical records

Patient Name: _____ **Date of Birth** _____

I authorize Idaho Falls Pediatrics to use or disclose Protected Health Information (PHI) contained in my Medical Records in the following manner:

To: Idaho Falls Pediatrics, 2375 Coronado, Idaho Falls, ID 83404 (208) 522-4600

| Doctor's name | City | State | Zip | Phone |
|---------------|------|-------|-----|-------|
| | | | | |

From:

| Person/Institution sending data | Fax # |
|---------------------------------|-------|
| | |

| Street Address | City | State | Zip | Phone |
|----------------|------|-------|-----|-------|
| | | | | |

Please Release the following Protected Health Information:

___ All Records ___ Chart Notes ___ X-Rays ___ Labs ___ Mental Health
___ Other (please specify):

The Protected Health Information is being used or disclosed for the following purpose(s): (If the patient is requesting the release, this may state "at patient's request")

(List specific purposes the Protected Health Information will be utilized)

Expiration date of release

This authorization is effective through ___/___/___ unless revoked or terminated by the patients parents or guardian.

I understand that I have the right to revoke this authorization in writing by sending notification to the address above

I understand that when I revoke this authorization, it is not effective to the extent that the clinic has already relied on the use or disclosure of the Protected Health Information.

I understand the Protected Health Information released pursuant to this authorization might be re-disclosed by the party who receives that information and may no longer be protected by federal or state law.

The clinic will not base my treatment or payment on whether I provide an authorization for the requested use or disclosure, unless the provision of health care is solely for the purpose of creating Protected Health Information for disclosure to a third-party.

I understand that I have a right to inspect or copy the Protected Health Information to be used or disclosed.

I understand that I have a right to refuse to sign this authorization.

If you have any questions concerning this form, please contact the clinic manger.

Signature of Parent/Guardian _____ **Date** _____