

Idaho Falls Pediatrics

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Medical Record Release

Authorization to Release Medical Information and/or Medical Records

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

Address: _____
 Street Address City State Zip

Phone Number: _____

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

From: Idaho Falls Pediatrics, 3067 Eagle Dr. Ammon, ID 83406

Phone # (208) 522-4600 Fax # (208) 552-7521

Email (preferred) ifpediatrics@hushmail.com

To: _____
 Street Address City State Zip

Email (preferred) _____

Phone _____ **Fax** _____

Please release the following Protected Health Information:

___ All Records ___ Health & Physical ___ Immunizations ___ Labs
 ___ Other (please specify) _____

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 had already relied on the use of 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 manager.

Name of Parent/Guardian requesting record _____

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