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AUTHORIZATION TO ACCESS, USE, AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient: ____ Date of Birth: ____________________

Address: ____________________________City ______________State:__________Zip:_________

Telephone number:____________________ Home:________________Work:_________________

Release Information From: The following entity/individual is authorized to disclose my PHI:	**Release Information To:** The following entity/individual is authorized to disclose my PHI:
Name: ______________________________________	Name: ______________________________________
Address: ____________________________________ ____	Address: ____________________________________ ____
Phone: _____________________________________	Phone: _____________________________________
Fax: ____	Fax: ____

Purpose of Use and Disclosure:

□ Insurance □ Legal □ Personal □ Treatment/Continued Care □ Workers Compensation □ School

□ Occupational Services □ Employee Wellness □ Other ____

This request is valid for services for the following dates (select one of the following)

□ Approximate service date(s) ____

□ All visits between the dates ______________________________ and ____________________________

- **Please note: Paper records are required. Discs will not be accepted**

Information to be Used or Disclosed:

I understand that the information in my health record may include information relating to acquired immunodeficiency syndrome (AIDS), or

□ Billing Information	□ Immunization and/or Titers	□ Operative/Procedure Report
□ Discharge Summary	□ Lab/Pathology	□ Biometric Screening
□ Emergency Room Record	□ Medication List	□ Substance Use Disorder
□ History/Physical	□ Employment/DOT Physical	□ Drug and/or Alcohol Results
□ Clinic/Progress Notes	□ Therapy Notes	□ Imaging Report(s)
□ Mental Health Evaluation	□ Problem List	□ Imaging Disc w/report
□ Health Assessment	□ Consultation Reports	□ Other: (Specify) ____________________

human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and genetic testing.

I understand that I have the right to revoke this authorization at any time except to the extent that action has been taken in reliance on this authorization. To revoke this authorization, I must submit a written revocation to Medical Records at Treasure Valley Rheumatology.

I understand that my health care cannot be conditioned on this authorization unless the purpose is solely to obtain and disclose information for a third party, such as an employer.

I understand that information disclosed by Treasure Valley Rheumatology's pursuant to this authorization may be re-disclosed by the entity that receives this information and may no longer be protected by privacy regulations.

____ ____________________

Patient Signature Date

This Authorization will Expire One (1) Year from Date Signed.