Kootenai Health
2003 Kootenai Health Way
Coeur d' Alene , Idaho 83814−2677
p 208.625.6251 **f** 208.625.6247
HIMROI@KH.org

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the patient, _____ D.O.B. _____

Authorize the following person or business (please include address):

- ❑ **Kootenai Health**
- ❑ **Kootenai Clinic − Provider Name:**

_____

- ❑ **Kootenai Outpatient Imaging**
- ❑ **Kootenai Behavioral Health**
- ❑ **Kootenai Clinic Cancer Services**

Person or Business authorized to receive or obtain the information (check appropriate boxes):

❑ **TO RELEASE INFORMATION TO** ❑ **TO OBTAIN INFORMATION FROM** ❑ **VERBAL COMMUNICATION**

Name: _____

Address: _____

City/State/Zip: _____ Phone/Fax: _____

INCLUDE DATE(S) OF TREATMENT _____ **For Information to be disclosed (Written and/or Verbal)**

- ❑ Pertinent Information (Summary Reports, History and Physical, Lab, XRay,EKG)
- ❑ Emergency Dept. Records
- ❑ Operative Report
- ❑ Immunization Records
- ❑ Clinic/Progress Notes
- ❑ Lab/Pathology Reports
- ❑ Radiology Reports
- ❑ Radiology Images CD
- ❑ Other (please specify):

_____

THE PURPOSE FOR THIS RELEASE:

❑ Continuing Care ❑ Insurance Purposes ❑ Personal ❑ Legal Purposes ❑ Other _____

PATIENT AUTHORIZATION:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

Exclude the following information from the records released:

_____ Drug/Alcohol abuse/treatment & diagnosis
_____ HIV/AIDS diagnosis/treatment/testing
_____ Mental Illness or Psychiatric diagnosis/treatment
_____ Sexually Transmitted Disease
_____ Genetic Records

I understand that I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment.) I acknowledge that incomplete forms cannot be processed and that there may be a cost associated with this request.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. To revoke this authorization, I must submit my written request to the Health Information Department.

This authorization is valid until _____ OR when the following event occurs: _____(State when Kootenai Health is no longer authorized to disclose my information based on this authorization. If left blank, it will automatically expire one year from the date signed.) **NOTE**: Authorizations to disclose your information to an employer or financial institution can only be effective for a maximum of one year from the date signed by you.

I understand that once this information is disclosed it may no longer be protected by federal or state regulations and may be re−disclosed by the person or organization that received the information.

I understand that I am entitled to receive a copy of this authorization upon my request. A copy, fax or scan of this form is to be considered as valid as the original.

_____ _____

Signed* (Patient, Guardian, or Authorized Representative) Date:

*Please provide documents to prove authority to sign on behalf of the patient and state relationship.

❑ On Unit
❑ Mail
❑ In Person
❑ Fax
❑ CD

Identification Verified by HIM staff: ❑ Yes ❑ No ROI Staff Initials:_____

Date Received _____ Date Released: _____ # Pages: _____

Notes:_____ Who Released: _____

ROIX
KOOTENAI HEALTH
Coeur d'Alene, Idaho
AUTHORIZATION FOR RELEASE OF INFORMATION
999999−071 Rev. 02/2017