I, the patient,_____, D.O.B._____
authorize the disclosure of health information about me as described below.

Person or, Business authorized to disclose the information (please include address):

_____

_____

Description of Information to be disclosed from dates: _____ to _____

__ Complete Copy	__ Laboratory Results	__ Care Plans	__ H&P
__ Progress Notes	__ Operative Report	__ Discharge Summary	__ Facesheet
__ Consultation Notes	__ Discharge Instructions	__ Medication Admin Records	__ EKG
__ Radiology Reports	__ Treatment Plans	__ Pathology Report	__ Orders
__ Radiology Films	__ Psychiatric Eval	__ Immunization Records	__ Rehab Reports
__ School Records*	__ Psychiatric Testing	__ Emergency Dept. Record	__ Nursing Notes

__ Other (Specify): _____

I give special permission to release any information regarding:
__ Substance Abuse __ HIV Information __ Psychiatric/Mental Health

The information will be used/disclosed for the following purposes:
__ Continuing Care __ Insurance Purposes __ Personal __ Legal Purposes __ Viewing
__ Other (Specify): _____

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulation, the information described above may be re-disclosed and no longer protected by these regulations. However the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used/disclosed under this authorization. There may be a charge for these copies.

This authorization will automatically expire six months from the date signed. I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance thereon. To revoke this authorization, I must submit my request in writing to Kootenai Outpatient Surgery Medical Records.

Signed**: _____ Date: _____
(If not patient, state relationship)

*Includes Cumulative file/transcripts; Discipline/Expulsion Records; Special Services File
**This authorization must be completed prior to obtaining the original signature. Copies or original authorizations are considered original.

_____

Date received: _____ Date released: _____ (Mailed___ In Person___ Fax____)
Initials: _____

Kootenai Outpatient Surgery
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