Kootenai Health
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Coeur d' Alene, Idaho 83814−2677
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HIMROI@KH.org

AUTHORIZATION FOR RELEASE OF INFORMATION

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

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)**

Hospital Records

❑ Emergency Dept. Records
❑ Operative Report
❑ Discharge Summary
❑ History & Physical
❑ Progress Note
❑ Lab/Pathology Reports
❑ Radiology Reports
❑ Other (please specify): _____

Clinic Records

❑ Clinic office visit Date(s) of Service: _____ Clinic location/provider: _____

Other (please specify): _____

THE PURPOSE FOR THIS RELEASE IS: _____

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.

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