KootenaiHealth

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. _____

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

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

Name: Legal Guardian:

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): Discharge Instructions Psychiatric Evaluation and any testing (Psych, CNS Vitals, ADOS)

Clinic Records

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

Other (please specify): _____

THE PURPOSE FOR THIS RELEASE IS: Personal and Continued Care

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:_____ ☐ Mail ☐ In Person ☐ CD

Date Received: _____ Date Released: _____ #Pages: _____ Who Released: _____

Acct #: _____ MRN #: _____

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

Name: Primary Care Dr. ;

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): Discharge Instructions psychiatric evaluation and tny testing completed (psych, CNS Vitals, ADDS)

Clinic Records

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

Other (please specify): _____

THE PURPOSE FOR THIS RELEASE IS: Continued care

PATIENT AUTHORIZATION:

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

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Name: Psychiatrist's

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): Discharge instructions psychiatric evaluation and any testing completed (psych, CNS vitals, TBOS)

Clinic Records

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

Other (please specify): _____

THE PURPOSE FOR THIS RELEASE IS: Continued Care

PATIENT AUTHORIZATION:

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

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

Name: Therapist: _____

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): Discharge Instructions psychiatric evaluation and any testing completed (Psych, CNS Vitals, ADOS)

Clinic Records

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

Other (please specify): _____

THE PURPOSE FOR THIS RELEASE IS: Continued Care

PATIENT AUTHORIZATION:

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_____ Sexually Transmitted Disease
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Person or Business authorized to receive or obtain the information (check appropriate boxes):

☒ TO RELEASE INFORMATION TO ☒ TO OBTAIN INFORMATION FROM ☒ VERBAL COMMUNICATION

Name: School

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): Discharge Instructions and School Work Collaboration

Clinic Records

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

Other (please specify): _____

THE PURPOSE FOR THIS RELEASE IS: Continued Care

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:

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

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

Name: Insurance Co:

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): testing, psychiatric eval and discharge instructions

Clinic Records

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

Other (please specify): _____

THE PURPOSE FOR THIS RELEASE IS: Financial and Continued Care

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
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_____ Mental Illness or Psychiatric diagnosis/treatment
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Identification Verified by HIM staff: ☐ Yes ☐ No ROI Staff Initials:_____ ☐ Mail ☐ In Person ☐ CD

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

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

Name: Idaho Health and Welfare

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): Discharge instructions psychiatric evaluation and discharge instructions

Clinic Records

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

Other (please specify): _____

THE PURPOSE FOR THIS RELEASE IS: Continued Care

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.

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

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

Name: Probation or Diversion Officer:

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): Discharge Instructions, psychiatric evaluation, Any testing completed (psych, CNS Vitals, AODS)

Clinic Records

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

Other (please specify): _____

THE PURPOSE FOR THIS RELEASE IS: Continued Care

PATIENT AUTHORIZATION:

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