Authorization for Release of Information

Kootenai Health – Medical Records
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✱ 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: School Name:

Address: ____________________

City/State/Zip:____________________ Phone/Fax: ____________________

INCLUDE DATE(S) OF TREATMENT Admit to discharge **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): School work and IEP/504 and any testing along w/ Discharge instructions

Clinic Records

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

Other (please specify): ____________________

THE PURPOSE FOR THIS RELEASE IS: Care Coordination and Support

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
______Sexually Transmitted Disease
______HIV/AIDS diagnosis/treatment/testing
______Genetic Records
______Mental Illness or Psychiatric diagnosis/treatment

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 #: ____________

Patient Identification – Write in or attach patient label

Name:

MRN #:

CSN #:

DOB/Sex:

999999-071
ROI- Other