Center for Lifetime Health

AUTHORIZATION TO RELEASE
CONFIDENTIAL MEDICAL INFORMATION

PATIENT NAME			DATE OF BIRTH
ADDRESS			PHONE NUMBER
CITY	STATE	ZIP	E-MAIL

I hereby request that a copy of summary of my records, INCLUDING LABORATORY or X-RAY reports that you may have which contain information relevant to my present and future diagnosis and/or treatment be released to: **Center for Lifetime Health:**

Records Will Be Requested From:

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

SPECIFIC AUTHORIZATION

I acknowledge that data to be released may include material that is protected by federal law and that is applicable to ANY or ALL of the above. My signature below authorizes release of all such information except as otherwise specified.

Substance Abuse
Mental Health Treatment Information
HIV (AIDS) Test Results

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I *d*o have to sign an authorization form:

- To take part in a research study.
  or
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Center for Lifetime Health based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Once this office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature	Date	Time
Printed name if signed on behalf of the patient	Relationship (parent, legal guardian, personal representative, etc.)	

Center for Lifetime Health
300 E. Bannock Street
Boise, ID 83712

Phone: (208) 342-7400
Fax: (208) 342-1879