Center for Lifetime Health

300 E Bannock St. Boise, ID 83712

(208)342-7400

Fax: (208)342-1879

RELEASE OF INFORMATION

Date _____

Patient Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Phone Number _____ Email _____

Records requested from: _____

Address _____ City _____ State _____ Zip _____

Phone Number _____ Fax Number _____

I request and authorize my information to be released to: _____

Address _____ City _____ State _____ Zip _____

Phone Number _____ Fax Number _____

Health Information to be disclosed (check all that apply):

- ○ Billing Records
- ○ Chart Notes
- ○ Lab Reports
- ○ X-ray/Diagnostic Reports
- ○ Medication List
- ○ Immunization
- ○ Appointment Information
- ○ Other: _____

Approximate dates of service (last two years unless otherwise specified): _____

I understand that my medical record may include information on the diagnosis/treatment related to psychiatric, psychological, or mental conditions, drug and/or alcohol use and/or abuse, sexually transmitted diseases (STD), acquired immune deficiency syndrome (AIDS), human immunodeficiency virus (HIV) status, and/or genetic testing. I consent to the following being disclosed: ***PLEASE INITIAL ALL THAT APPLY***

____ Psychiatric/psychological/mental conditions

____ Drug and/or alcohol use and/or abuse

____ Sexually Transmitted Diseases (STD)

____ Acquired Immune Deficiency Syndrome (AIDS)

____ Human Immunodeficiency Virus (HIV) status

____ Genetic Testing

If expiration date is not specified, this request will expire twelve months from the signature date.
I understand that 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 by this authorization.
I understand that I may revoke this authorization at any time by notifying Center of Lifetime Health in writing, and if I do, it will not have any effect on any actions Center of Lifetime Health took before they received the revocation.
The information disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by federal law. State and federal law specifically requires that any patient medical record and/or personal health care information containing drug and alcohol diagnosis and treatment, mental health and sexually transmitted diseases, including HIV/AIDS are privileged and confidential and may only be disclosed by express authorization, except as required by law. I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug abuse Patient Records, 42 CFR Part 2 and Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Signature _____ Date _____

Printed Name(if signed on behalf of patient) _____

Relationship to patient _____