Eastern Idaho Public Health

Prevent. Promote. Protect.

Authorization to Release Information

Client Name: _____
Last First Middle Initial

Former Name(s): _____ Date of Birth: _____

I hereby authorize:

Healthcare Provider/ Individual: Eastern Idaho Public Health

Mailing Address: _____

City: _____ State: _____ Zip code: _____

Phone Number: _____ Fax Number: _____

To disclose the protected health information described below to:

Healthcare provider/ Individual: _____

Mailing Address: _____

City: _____ State: _____ Zip code: _____

Phone Number: _____ Fax Number: _____

The authorization release of information covers the period of healthcare from:

☐ Date: _____ to _____

☐ **I authorize the release of my complete health record, WIC record excluded (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).**

Or

☐ **I authorize only the following health records to be released:**

☐ Immunization Record ☐ Pathology & Labs Reports ☐ Pap Reports ☐ Billing

☐ WIC (Specify): _____

☐ Other (Specify): _____

I understand that:

- This medical information may be used by the healthcare provider or individual I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purpose as I may direct.
- My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- Information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
- I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

This authorization is valid for one year and is subject to revocation in writing by the signed individual below at any time.
WIC excluded from above statement and form is valid for one time use only.

_____

Printed name of client or personal representative and his or her relationship to client

_____

Signature of client or personal representative **Date**

This institution is an equal opportunity provider.

07/2022 AG