IDAHO HAND INSTITUTE

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Medical records released from:

_____
Provider/Entity Name

_____
Address

_____
City, State, Zip

- ☐ Office notes
- ☐ Medication records
- ☐ Lab reports
- ☐ Radiologic images and reports
- ☐ Complete hospital chart
- ☐ Discharge summary
- ☐ Outpatient records
- ☐ Consultation notes or Reports
- ☐ Other: _____

_____

This information will be used for the purpose of diagnosing, treating, providing other services as deemed necessary, and other activities at the request of the patient.

I authorize the above named health care provider/entity to release the information or records specified to Idaho Hand Institute upon request using the method indicated below. This authorization will expire one year from the date of the signature below. I understand that I can revoke this authorization at any time by writing to Idaho Hand Institute or to the above named provider/entity and that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

Records authorized to be released to:

Idaho Hand Institute
444 Hospital Way Ste 710
Pocatello, ID 83201
Phone: 208-235-4263
Fax: 208-233-4268
Email: contact.us@idahohandinstitute.com

- ☐ I will pick them up
- ☐ Please mail
- ☐ Please fax
- ☐ Please send via secure email

I also understand that:

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- Federal privacy regulations will no longer apply to the information disclosed, and that Idaho Hand Institute may redisclose the information.
- I am entitled to receive a copy of this authorization.
- A copy of this authorization may be utilized with the same effectiveness as an original

_____
Patient's Name (Please Print)

_____
Date of Birth

_____
Signature

_____
Date

_____
If applicable: Parent or Guardian (Please Print)