Kootenai Urgent Care

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name___________________________________ DOB ______________ SS# ______________________
Address ____Phone (   ) ____________________

I authorize **[provider name and address]** ____to use and/or disclose my health information as identified below to:

☐ Patient at the same address above ☐ pickup ☐ mail ☐ fax: (   )______________________

☐ Other (include name or office, address, phone, fax) ____

____

Purpose(s): ☐At the request of the patient ☐Doctor/Continued Care ☐Attorney ☐Financial
☐Other as noted____

By initialing the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist:

______Please send the entire medical record (all information) to the above named recipient.

______Medical records from __________ to __________ ______Billing statements

______Laboratory and/or Pathology reports ______Diagnostic imaging reports

______Other____

Federal regulations require a description of how much and what kind of the following information is to be disclosed. The following items must be individually initialed to be included in the use or disclosure of other health information: Federal law prohibits the re-disclosure of such information.

_____ *HIV / AIDS related health information and/or records

_____ *Sexually Transmitted Disease information and/or records

_____ *Birth Control/Pregnancy information and/or records

_____ *Drug/alcohol diagnosis, treatment and/or referral information

_____ *Mental health information and/or records

_____ *Genetic testing information and/or records

_____ Other ________________________________

_____ *Restricted protected health information

Agreement must be terminated in writing or documented oral agreement to restrict disclosure.

____ ***Psychotherapy notes** (If this authorization is for the use and/or disclosure of psychotherapy notes, then it cannot be combined with any other authorization.)

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer of Kootenai Urgent Care. Unless revoked earlier, this authorization will expire 180 days from the date of signing or upon **[insert applicable date or event of expiration]** _____________________________________. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by federal privacy laws or regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations. I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

SIGNATURE Patient____ Date ______________

Printed Name ____

If other than patient, indicate RELATIONSHIP: ☐ Parent ☐ Guardian ☐ Legal Representative ☐ Power Of Attorney

Office Use Only

Identity of patient and/or signature verified with: ☐ Photo ID ☐ Matching Signature ☐ Other _____________

Verified by (print): ____ Date: __________

Request completed by (print): ________________________________ Date: __________

Please allow at least 5 business days for records to be prepared. There may be a charge for these purposes.
A copy of this signed form can be provided to the individual and/or the individual’s legal representative.

Revision: April 2009