Heritage Health
Healthcare from the Heart

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO HERITAGE HEALTH

Name: _____ (Last) _____ (First) _____ (MI)

Previous Name: _____ (Previous Name)

DOB: _____ Phone: _____ ☐ Home ☐ Cell

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

I, the patient _____ authorize the release of health information about me as described below:

1. INFORMATION TO BE RELEASED FROM:

Organization or Person: _____

Address: _____ (Street or PO Box) _____ (City) _____ (State) _____ (Zip)

Phone: _____ Fax: _____ Email: _____

2. INFORMATION TO BE RELEASED TO:

Organization or Person: Heritage Health

Address: P.O. Box 1387 (Street or PO Box) Hayden (City) ID (State) 83835 (Zip)

Phone: 208-415-0294 Fax: 844-807-3782 Email: medicalrecords@myheritagehealth.org

3. WHAT INFORMATION TO BE RELEASED:

☐ Information from last visit plus 2 years prior.

☐ Information from date **(YOU MUST INDICATE DATES)**: from: _____ to: _____

☐ Specific information (please specify): _____

☐ I authorize **VERBAL COMMUNICATION** about my medical history and care to the person listed in section 2.

4. THIS RECORD IS REQUESTED FOR THE FOLLOWING REASON (REQUIRED):

☐ Transfer of Care to (Name of Provider): _____

☐ Going to Specialist ☐ Insurance Purposes ☐ Personal Interest ☐ Legal Purposes

☐ Other (please specify):

5. METHOD TO RELEASE RECORDS: ☐ Fax ☐ Mail Paper ☐ Mail CD ☐ Email

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6. SENSITIVE RECORDS: ! ***"Do Not Send"***

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 **EXCLUDED** 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.)

I understand that if the person or entity that receives the 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 these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand 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 under this authorization. I also understand there may be charges for these copies.

I understand I may revoke this authorization at any time by notifying Heritage Health in writing. However, the revocation will not have any effect on any action Heritage Health prior to receiving your written notice.

7. Signature:_____ **Date:**_____

(Patient or Member, Guardian, or Authorized Representative*)*
*[*Documentation may be required to prove authority to sign on behalf of the patient.]*

8. Minor's Signature:_____ **Date:**_____

(Signature of minor ages 13-17 is required for certain information.)

9. Authorization expires one year from date signed or on date/event indicated here:_____

STAFF USE ONLY

Date Received:_____ Initial_____ Date Released:_____ Initial_____