Heritage Health

AUTHORIZATION TO RECEIVE AND/OR RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

Address: _____

City/State/Zip: _____ Phone: _____

I, the patient, _____ authorize the disclosure of health information about me as described below.

Person or business authorized to RELEASE the information (please include address):

_____

_____

Person or business authorized to RECEIVE the information:

Heritage Health Dental
1090 W Park Place,
Coeur d'Alene, ID 83814

Email: **dentalimage@myheritagehealth.org**
Phone: **208.292.0697**
Fax: **208.292.0357**

Description of the information to be released:

- ☐ Discharge Summary
- ☐ Med List
- ☐ Treatment Plan
- ☐ Progress notes
- ☐ X-Rays
- ☐ Laboratory Results
- ☐ Radiology Reports
- ☐ Immunization Records
- ☐ Pathology Report

☐ One Year ☐ Two Year ☐ Five Year ☐ Other (please specify): _____

_____

I give special permission to release my information regarding:

☐ Substance Abuse ☐ Psychiatric/Mental Health ☐ HIV Information

- I understand that if the person or entity that receives the information is not a healthcare 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, 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.
- This authorization will automatically expire six months from the date signed. I understand that I may revoke this authorization at any time to the extent that action has been taken in reliance thereon. To revoke this authorization, I must submit my request in writing to the Medical Records Department.
- I understand that records deemed not appropriate to keep, by my Heritage Health provider, will be destroyed.

Signed: _____ **Date:** _____

Relationship to Patient: _____

***This authorization must be completed prior to obtaining the original signature. Copies or original authorizations may be considered originals.**

Office use only: Date received/initials: _____ *Date released/initials:* _____

REV. 06/19