Mountain View Hospital
PROUD TO BE PHYSICIAN OWNED

Authorization of Medical Records Release of Information Disclosure

Please complete all sections of the form and attach required documentation to ensure timely processing

I, _____ *(Patient/Patient Representative)*, authorize _____
(Facility/Department)

to release protected health information (medical records) for the individual named below:

Patient Last Name:_____ **Patient First Name:** _____

Patient Date of Birth:_____ **Phone Number:**_____ **Previous Last Name (if applicable):** _____

Street Address:_____ **City:**_____ **State:**_____ **Zip Code:** _____

The Purpose of this disclosure is:

☐ Medical Care or Consultation ☐ Billing or Claims Payment ☐ Personal Use ☐ Legal ☐ Other: _____

Date(s) of Service: *from*_____ *thru* _____

Information to be released: *(A copy fee of $1.00 per report will be charged if applicable)*

☐ Lab Reports ☐ Radiology Reports: Disc Images_____ Reports _____ ☐ EKG ☐ Operative Reports ☐ Itemized Bills

☐ Chart Notes (Face sheet, History & Physical, Operative Report, Discharge Summary, Consultations, and Discharge Instructions)

☐ Other: _____

I understand that if my medical or billing record contains information in reference to the conditions described below, **I must agree to the release by initialing on each applicable line:**

_____ HIV/AIDS testing or treatment

_____ Psychiatric treatment (excluding psychotherapy notes)

_____ Genetic testing records

_____ Sexually transmitted diseases

_____ Drug or Alcohol Abuse Records (diagnosis, treatment, or referral, excluding counseling notes)

_____ Hepatitis B or C testing

Information to be released to: ☐ Self - same as above information

Name of Third Party Receiving Records: _____

Phone Number:_____ **Fax Number:**_____

Street Address:_____ **City:**_____ **State:**_____ **Zip Code:** _____

This authorization will expire in one (1) year unless an earlier date is specified: _____

(continued on reverse side)

Patient Sticker
Last_____
First_____
DOB_____
MRN _____

PART OF THE MEDICAL RECORD.
SCAN AFTER COMPLETION.

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I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

I understand that I may revoke this authorization at any time by giving written notice to the Director of Health Information Management, 2325 Coronado St., Idaho Falls, ID 83404. I understand that revocation will not affect any action **Mountain View Hospital** took by relying on this authorization before they received my written notice.

I understand that this authorization to use or disclose protected health information is voluntary and **Mountain View Hospital** cannot deny or withhold health care services if I do not sign the authorization, except if the authorization is required for a research study in which I am enrolled, or if the service is solely for a third-party (pre-employment physical, etc.).

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, and genetic information.

Signature of Patient: _____ Date/Time: _____

☐ *Patient unable to sign:* _____
(Reason)

Authorized Agent Printed Name: _____ *Relationship:* _____

Signature of Authorized Agent: _____ *Date/Time:* _____

Name of Witness: _____ Title: _____

Signature of Witness: _____ Date: _____ Time: _____

For Staff Use

Records to be released via ☐ US Mail ☐ Fax ☐ Personal Pick-up ☐ Emailed Paper Copies (including faxes CD/DVD)

Form of ID or Proof Submitted:

☐ Driver's License
☐ Guardianship/Conservator Orders
☐ Durable Healthcare Power of Attorney
☐ Other: _____
☐ Birth Certificate
☐ Death Certificate
☐ Signature Verification

Patient Identification or Proof of Authority to Authorize Release verified/processed by:

Printed Name: _____ Title: _____ Date: _____

Patient Sticker
Last _____
First _____
DOB _____
MRN _____

PART OF THE MEDICAL RECORD.
SCAN AFTER COMPLETION.