



6195 Hunt Ave.  
Nampa, ID 83687  
Main: (208) 926-6300  
Fax: (208) 466-7004

## Authorization for Disclosure of Protected Health Information

\_\_\_\_\_  
(Print name of patient)

\_\_\_\_\_  
(Birth date)

\_\_\_\_\_  
(Street address)

\_\_\_\_\_  
(City, state, zip code)

\_\_\_\_\_  
(Phone number)

Many times our patients allow family members such as their spouse, parents or others to call and request medical or billing information. If you wish to have your verbal medical or billing information and/or medical records released to family members or others, you must sign the form below.

This authorization is limited to the release of or discussions of the following medical condition(s):

\_\_\_\_\_  
(If no limitations are listed, release of information will be permitted regarding any medical condition for which the patient has received care.)

	Name	Phone Number	Relationship	Include Medical Records
1.	_____	_____	_____	Yes____ No____
2.	_____	_____	_____	Yes____ No____
3.	_____	_____	_____	Yes____ No____

This authorization is limited to the following timeframe from \_\_\_\_\_ (date) to \_\_\_\_\_ (date).

**If no dates are indicated, this form will remain in effect for one year from the date of signature.**

If at any time I want to revoke this consent, I must notify my Health Care Provider by contacting the Medical Records Department at Idaho Surgical.

Patients Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this release is signed by a representative on behalf of the patient, complete the following:

Representative's Name \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_