



TO REQUEST FROM

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

FOR THE RECIPIENT OF THE INFORMATION:

If any of the requested records contain information regarding alcohol or drug abuse treatment, it is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the use or release of medical or other information is **NOT** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

All boxes to be completed in FULL by the patient or the patient's authorized representative. (Please print) If not completed, request will be returned.

PLEASE PRINT PATIENT INFORMATION:

Patient Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: _____ Date of Birth: _____ SS# _____

PLEASE PRINT I HEREBY REQUEST AND AUTHORIZE:

Name: Terry Reilly Health Services

Address: 223 16th Avenue N, PO Box 9 City: Nampa State: ID Zip Code: 83653

Telephone: 208-466-7869 ext 6218-Medical Records Fax: 208-466-5359

PLEASE PRINT TO REQUEST INFORMATION FROM:

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____

In the following manner: For the following purpose(s): My Authorization for the use and disclosure of the following records:

<p>SELECT ONE:</p> <input type="checkbox"/> By mail <input type="checkbox"/> By fax (may not be secure) <input type="checkbox"/> Copies to be picked-up which clinic _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> CD (X-ray images may not be secure) <input type="checkbox"/> USB <input type="checkbox"/> Email: _____ <input type="checkbox"/> Uploaded to secure site	<input type="checkbox"/> To provide treatment <input type="checkbox"/> Coordination of care <input type="checkbox"/> To conduct an evaluation <input type="checkbox"/> At the request of the patient <input type="checkbox"/> Other _____	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Allumbaugh House* <p>* Substance Abuse Records are covered by CFR 42</p>	<p>Check all that apply:</p> <input type="checkbox"/> Charges, payments, and billing information <input type="checkbox"/> Treatment records/progress notes/summaries <input type="checkbox"/> X-ray reports and other images <input type="checkbox"/> Images on CD/USB <input type="checkbox"/> Lab tests <input type="checkbox"/> Accounting of visits <input type="checkbox"/> Dental records <input type="checkbox"/> AIDS or HIV information history/physical/evaluation <input type="checkbox"/> Police/investigation reports <input type="checkbox"/> Other _____ <p>*For Substance abuse records-How much and what kind of info to be disclosed, including explicit description of the substance use disorder info that may be disclosed</p>
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Records created on or during the following time period:

 Standard records (last 6 office visits, recent physicals, growth charts, vaccines, problem lists, labs, hospital notes)
 Other _____

This authorization will expire on _____*CFR 42 Part 2 authorization release cannot be longer than reasonably necessary to serve the purpose.

My authorization is given freely with the understanding that:

- My information may be subject to re-disclosure by the recipient and may no longer be protected by Terry Reilly Privacy Practices or applicable privacy laws.
- I may revoke this authorization at any time, except where information has already been released in reliance on my authorization, provided that my revocation is in writing.
- Terry Reilly may not condition my treatment on my provision of this authorization.
- This authorization is valid for a 12-month period from the date it is signed unless otherwise specified.
- A photocopy or fax of this authorization is as valid as the original.
- Terry Reilly, its directors, officers, employees, agents and volunteers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ Signature of Patient or Responsible Party	_____ Date	
_____ Name of Parent or Personal Representative (please print)	_____ Relationship to Patient	_____ Name & Designation of Employee Receiving Form/Assisting Patient (PRINT NAME)