

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

**PATIENT NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE OF BIRTH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

This is to authorize that medical information regarding the above person be released:

TO/FROM: Mark R. Miller, MD • John L. Bennion, MD

Bret D. Williams, OD • Rob D. Christensen, OD

3045 E. St. Luke’s Street Suite #100 Phone: (208) 288-2020

Meridian, ID 83642 Fax: (208) 288-2015

TO/FROM:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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PURPOSE OR NEED FOR RECORDS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COPIES OF RECORDS REQUESTED:

FROM DATE:\_\_\_\_\_\_\_\_\_\_TO DATE:\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_CURRENT RECORDS

(Check all that apply) \_\_\_\_\_PROGRESS NOTES

\_\_\_\_\_LAB REPORTS

\_\_\_\_\_X-RAY REPORTS

\_\_\_\_\_HOSPITAL RECORDS

\_\_\_\_\_OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that my records may contain information regarding drug or alcohol abuse, mental illness, psychiatric treatment, and/or sexually transmitted diseases, including HIV (AIDS) information. I give my specific authorization for these records to be released.

This authorization is valid for six months unless revoked in writing earlier. Any redisclosure of information obtained by this authorization is prohibited except with the written consent of the patient.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_