TREASURE VALLEY ENDOCRINOLOGY, P.C.
900 N. LIBERTY SUITE 201 BOISE, IDAHO 83704
PHONE (208) 367-6740, FAX (208) 367-6742

AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

PATIENT NAME:_____D.O.B_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____PHONE:_____

I hereby request that a copy of my or my dependent's confidential medical records be sent as requested below:

FROM:_____TO:_____

_____

_____

Specific data requested:_____

_____

Route of delivery: MAIL_____ FAX_____ PICK UP_____

I understand that the data to be released may include information concerning substance abuse, mental health, HIV or AIDS unless excluded below by circling:

IF CIRCLED, DO NOT RELEASE INFORMATION CONCERNING:

SUBSTANCE ABUSE MENTAL HEALTH TREATMENT HIV OR AIDS

My signature below authorizes release of all medical information for me or my dependent except as otherwise specified. ***Authorization expires 1 year from date signed.***
Records exceeding 20 pages will be subject to a fee. Please allow 10 working days to process your request.

_____

Patient Signature **Date**

*This information has been disclosed from records whose confidentiality is protected by federal law (42CFR, p.2). These regulations prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical records or information is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500 in the case of the first offense and not more than $5000 in the case of each subsequent offense.

*The PHI contained in this FAX is HIGHLY CONFIDENTIAL. It is intended for the exclusive use of the addressee. It is to be used only to aid in providing specific healthcare services to this patient. Any other use is a violation of Federal Law (HIPPA) and will be reported as such.

*SEE BACK of SHEET for ADDITIONAL INFORMATION REGARDING YOUR MEDICAL RELEASE.

Medical Release Information for Patients

- All record requests have to have a signed release. Please allow 7-10 business days to process your request. There is no charge for the most recent 20 pages of your file.

- Records exceeding 20 pages require a fee. We request payment when records are sent. You will receive a bill for these fees if not paid at time of release. The fees are as follows:

  ≤ 20 pages – courtesy no charge if faxed
  ≤ 20 pages - $10 if released on disc
  21-50 pages - $20.00
  > 50 pages- $50.00

- In many cases as outlined above, we charge a fee to release your medical record. These fees cover our costs for labor, supplies and postage. We do our best to accommodate your request and to keep the cost to a minimum. See HIPPA CFR 164.524.

- Records released to you will preferably be copied and sent to you on a disc. You are then able to share your records with whomever you wish. If you do not want them on disc and want a paper copy there may be an additional mailing fee for large files. You are also welcome, but not required, to come into the office to pick them up. Email is unsecured and discouraged unless a waiver is signed.

- We encourage patients to ask for copies of labs and results at their appointments which are released at no charge.