

TREASURE VALLEY ENDOCRINOLOGY P.C.  
900 N. LIBERTY, SUITE 201 BOISE IDAHO 83704  
PHONE (208) 506-7111, FAX (208) 506-7112

AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

AKA:

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: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SPECIFIC DATA REQUESTED: \_\_\_\_\_

\*SEE BACK FOR CHARGES IF APPLICABLE

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:

SUBSTANCE ABUSE                  MENTAL HEALTH TREATMENT                  HIV/AIDS

My signature below authorizes release of all medical information for me or my dependent except as otherwise specified, and this authorization expires 1 year from date signed.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE SIGNED

This information has been disclosed from records whose confidentiality is protected by federal law. These regulations prohibit you from making any further disclosure of the 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.

## 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.