REQUEST FOR RELEASE OF MEDICAL RECORDS

2315 8th Street • Lewiston, ID 83501 • Tel: (208) 746-1383 • Fax: (208) 746-6348

Patient Name: _____ Date of Birth: _____

Patient Phone Number: _____ Appointment Date: _____

I HEREBY REQUEST AND AUTHORIZE YOU TO FURNISH ALL THE REQUESTED MEDICAL INFORMATION:

	RECORDS FROM:	**RECORDS TO:**
Provider or Group Name:		
Mailing Address:		
City, State and Zip Code:		

THE INFORMATION I REQUEST TO BE RELEASED IS:

- ❑ Any information concerning the patient's health care or payment during the relevant time period.
- ❑ Medical records concerning the patient's health care during the relevant time period, including:
  - ❑ Records from the patient's chart (IE: history, examination, progress notes, lab results, diagnostic test results, operative reports, discharge summaries, photographs, etc.)
  - ❑ Diagnostic images, films or other recordings (IE: x-rays, MRI scans, CT scans, etc.)
  - ❑ Psychotherapy notes **(Note: cannot be combined with authorization for other records).**
- ❑ Mutual exchange of information.
- ❑ Billing and payment records for health care rendered during the relevant time period.

PURPOSE – PRACTICE MAY USE OR DISCLOSE THE INFORMATION FOR THE FOLLOWING PURPOSE(S):

- ❑ The disclosure is made at the patient's request.
- ❑ For a potential or pending legal action.
- ❑ For marketing purposes. Practice WILL / WILL NOT (circle one) receive remuneration from a third party for the use or disclosure of the information.
- ❑ Other: _____

THE TIME PERIOD OF RECORDS THAT I REQUEST TO BE RELEASED IS:

❑ All Dates ❑ From: _____ To: _____

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing and it will be in effect on the date notified except to the extent action has already been taken.
- I understand that by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.
- I understand that Catalyst Medical Group, PLLC cannot limit or control the subsequent use or dissemination of medical information by the party to whom I request the information be furnished. This request is a free and voluntary act by me. I hereby release Catalyst Medical Group, PLLC and its staff from all legal responsibility that may arise from the release of medical information hereby authorized.

There is no charge when records are sent to a physician for continuing care. A copying fee is charged when records are released to a patient or other non-physician recipient. The copy charge is required cash day of service.

CONSENT OF MINOR AGED 14-17

If the patient is 14 years of age or older, **only the patient may authorize the disclosure of information relating to treatment** for contraception, pregnancy termination, sterilization, sexually transmitted disease, mental health conditions, alcoholism or drug abuse. I understand that my signature below authorizes the release of this information. *A photocopy of this authorization shall be considered as effective as the original.

⌦ Parent/Guardian Signature: _____ Date: _____

⌦ Patient Signature: _____ Date: _____

AUTHORIZATION IS VALID FOR ONE YEAR Expiration Date: _____

Give a copy of the authorization to the patient or personal representative Staff Initials: _____

Would you like to receive the requested information in an electronic format? (CD vs. paper?) ❑ YES ❑ NO

**** PLEASE ALLOW 30 WORKING DAYS FOR COPYING AND PREPARING RECORDS ****