ST. JOSEPH
Regional Medical Center

415 6th Street, Lewiston, Idaho 83501
(208)799−5309
Fax (208)746−3832

Patient Name:_____
Birth Date:_____
Address: _____
Phone Number: _____
Medical Record Number: _____
❑ Pick up Copies ❑ Fax Copies _____
❑ Mail Copies ❑ View Record
ID Confirmed by: _____

AUTHORIZATION OF DISCLOSURE OF HEALTH INFORMATION

I hereby authorize St. Joseph Regional Medical Center to disclose health information as specified:

To:_____
Name of Organization / Person to receive the health information

_____ _____
Street Address *Phone Number*

_____
City *State* *Zip Code*

Purpose or need for data: _____

Information to be disclosed: Date(s) of Hospitalization/Care: _____

- ☐ Discharge Summary
- ☐ History & Physical Exam
- ☐ Consultation Reports
- ☐ Operative Reports
- ☐ Lab
- ☐ Other: Specify _____
- ☐ Pathology
- ☐ Radiology Reports
- ☐ Radiology Films
- ☐ Psych Evaluation
- ☐ Entire Record

I understand that the disclosure may include information relating to (check if applicable):

- ☐ AIDS or HIV
- ☐ Psychiatric or Mental Health Information
- ☐ Drug / Alcohol Abuse Information

I understand that the information to be released may include material that is protected by Federal Law (45 CFR Part 164) and that the information may be subject to redisclosure by the recipient and no longer be protected by the federal regulations. I understand that this authorization may be revoked in writing at any time by notifying the privacy office, except that revoking the authorization won't apply to information already released in response to this authorization. I understand that SJRMC will not condition treatment, payment, enrollment or eligibility for benefits on my authorization. **Unless other wise revoked, this authorization will expire in 90 days from the date below or in the event of the following condition:**_____

St. Joseph Regional Medical Center, its employees, officers, copy service contractor, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized by me on this form and as outlined in our Notice of Privacy Practices. My signature below authorizes release of all information specified in this authorization. Any questions that I have regarding disclosure may be directed to the privacy officer at (208) 799−5486.

_____ _____
Signature of Patient *Date*

_____ _____
Signature of Legal Representative & Relationship to Patient/Authority to Act *Date*

_____ _____
Signature of Witness *Title* *Date*