Gritman MEDICAL CENTER

700 South Main Street
Moscow, ID 83843
Phone: (208) 883-6092
Fax: (208) 883-6559

1ROI

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

❑ Hospital ❑ Clinic: _____

Full Name _____ Date of Birth _____

Address _____ City _____ State & Zip _____

Day Phone # _____ Cell # _____

❒ RELEASE TO

Name _____

Address _____ City _____ State & Zip _____

Day Phone # _____ Fax # _____

❒ RELEASE FROM

Name _____

Address _____ City _____ State & Zip _____

Day Phone # _____ Fax # _____

RELEASE FORM/DELIVERY

I would like my copies to be: ❑ Standard Mail ❑ Fax ❑ Email: ❑ Pickup ❑ Certified Mail (Add'l Charge)

PURPOSE

❑ Continuation of Care (no fee) ❑ Personal ❑ Legal ❑ Insurance ❑ Other _____

TREATMENT DATE(S)

❑ Treatment Dates From _____ to _____

❑ All Treatment Dates ❑ Major Documents for the Last 3 Years

INFORMATION TO BE RELEASED/DISCLOSED

❑ I would like copies of the entire visit for the treatment dates listed above.

❑ I would like copies of specific reports for the treatment dates listed above. (Check reports below.)

I understand that the information to be released may include a diagnosis or reference to the following condition(s): behavioral health services/psychiatric care, sickle cell anemia, genetic testing, acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV), or drug and/or alcohol abuse.

❑ Billing Record	❑ Discharge Summary	❑ Immunization Record	❑ Pertinent Info. (D/S, H&P, X-Ray, Operative, EKG, etc.)	❑ Radiology Reports
❑ Cardiac Studies	❑ ED Reports	❑ Laboratory		❑ Therapy
❑ Clinic/Office Visit	❑ Genetic	❑ Mental Health/Psych		❑ Other
❑ Consultation	❑ History & Physical	❑ Operative	❑ Radiology Image CD	

I UNDERSTAND THAT

Without my express revocation, this authorization will automatically expire 90 days from the date signed below, unless I request an expiration date more or less than 90 days. I may choose to revoke this authorization at any time, except to the extent that action has already been taken to comply with it, by notifying GMC Expiration Date:_____ (no greater than one year). If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations. You may refuse to sign this authorization. You may inspect or copy the protected health information to be used or disclosed under this authorization. You may revoke this authorization in writing at any time by sending written notification to Privacy Officer at Gritman Medical Center, 700 South Main St., Moscow, ID 83843. Your notice will not apply actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.

Patient/Guardian Signature: _____ Date:_____

❑ Request Completed

_____ Date:_____

ROI Clerk OR Registration STAFF

Patient Demographics

Authorization to Release Protected Health Information