AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name:_____ Date of Birth:_____

Dates of Information Requested:_____

This is to authorize medical information from Idaho Hand Center on _____
(Myself, My Child, Etc…)

be release to:

_____ Fax#:_____

_____

_____

Information Requested:

- ☐ Operative Report
- ☐ Chart Notes
- ☐ History & Physical
- ☐ X-ray/Imaging (Films/Reports)
- ☐ Lab/Path
- ☐ Rehabilitation Notes
- ☐ Other:_____

DO NOT SIGN BEFORE READING THIS DISCLAIMER:

I herby release IDAHO HAND CENTER from all legal responsibility or liability for the release of the above mentioned information. I understand that I have the right to with draw this authorization at any time, and that such revocation must be in writing. Further, I understand that this authorization, without prior revocation, will expire 120 days from the date of signature.

SIGNATURE:_____ Date:_____
(Patient or person giving consent)

If other than patient, relationship to patient:_____

CAUTION: Please be advised that release of information authorized herein may result in the waiver by the patient of certain legal rights, including the protection of the physician/patient privilege and rights under the federal alcohol and drug abuse acts, and Idaho laws relating to involuntary commitment, mental illness or privacy about tests or treatment of sexually transmitted disease and/or HIV/AIDs. If you have any question about waiving these rights, you are advised to consult your attorney.

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