Pain Management of North Idaho
1686 W. Riverstone Dr. Coeur d' Alene, Id. 83814
Ph: 208-765-4807 Fax: 208-765-2903

Authorization to Release Medical Records

Name of Patient _____ Date of Birth _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

PATIENT INFORMATION IS NEEDED FOR:

- ☐ Continuing Medical Care
- ☐ Other: _____

INFORMATION TO BE RELEASED OR ACCESSED:

- ☐ Injection Reports_____
- ☐ Progress Notes_____
- ☐ Complete Medical Record
- ☐ Radiology Reports_____
- ☐ Lab/Path Reports_____
- ☐ Other: _____

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):
TO:

_____
(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

_____
Address (Street, City, State and ZIP)
FROM:

_____
(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

_____
Address (Street, City, State and ZIP)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire 1 year from the date of my signature, unless I revoke the authorization prior to that time.

Date: _____ Signature: _____
Patient or Legally Authorized Representative

_____
Printed Name of Representative & relationship to patient