# SALTZER CLINICS

## AUTHORIZATION OF USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| □ 215 E. Hawaii Ave.<br>Nampa, ID 83686<br>(208) 463-3229<br>Fax: 208 465-4825 | □ 9850 W. St. Luke's Dr.<br>Nampa, ID 83687<br>(208) 463-3229<br>Fax: 208 465-4825 | □ 8950 W. Emerald St..<br>Boise, ID 83704<br>(208) 463-3229<br>Fax: 208 465-4825 | □ 3277 E. Louise Dr.<br>Meridian, ID 83642<br>(208 463-3229<br>Fax: 208 465-4825 | □ 1818 S.10th<br>Caldwell, ID 83605<br>208 463-3229<br>Fax: 208 465-4825 | □ 7272 Potomac Ave.<br>Boise, ID 83702<br>208 463-3229<br>Fax: 208 465-4825 |

**REQUEST TO COPY PROTECTED HEALTH INFORMATION**

_______________________________________________ ______________ ______________
Patient's Name (Type or Print) Phone Number Date of Birth

___________________________________________________________________________
Full Address

**Please obtain information from:**

___Request for Medical Information
From Business Name:________________________
From Doctor: ____________________________
Address: ______________________________
City/State ________________Zip_________
Phone: ______________________________
Fax: ________________________________

**Please send information to:**

___Authorization to Release Medical Information
Send to: ____________________________
Address: ____________________________
City/State: ___________________Zip_____
Phone:______________________________
Fax: _______________________________

**Purpose of Release**: (The reason I am authorizing release.)
□ My request □ To provide my health information to another provider □ Other ________________________

**Information to be Used or Disclosed**

□ Complete health record
□ History & Physical / Progress Notes
□ Laboratory test results
□ Consultation Reports
□ Substance Abuse
□ X-ray film images
□ X-ray reports
□ Test results
□ Hospital Reports
□ Complete billing records
□ HIV/AIDS
□ Photographs
□ Other

Date(s) of service: ___________________________________________________________
The information covered by this authorization includes the information checked in the above paragraph:
*(Please write any additional requests here)*

___________________________________________________________________________

___________________________________________________________________________

□ Pick-Up Records □ Mail Records □ Fax Records □ E-Mail ____________________________

**Exclusions:**

- Psychotherapy Notes
- Information related to legal proceedings
- Information not included in your Medical Record
- You are a prison/correctional inmate and obtaining this information would risk the health, safety, security custody or rehabilitation of you or other inmates or would threaten the safety of officers, employees, other persons or your transporter(s) of the institution
- Information that federal or state laws prevent us from disclosing
- Information that is related to medical research in which you are currently participating. The information access is temporarily suspended for as long as the research is in progress.
- Information whose disclosure may result in harm or injury to you or to another person
- Information that was obtained under a promise of confidentiality.

ADDITIONAL INFORMATION

- You may revoke or terminate this authorization by submitting a written revocation to Saltzer Medical Group. You should contact the HIPAA Privacy Officer at (208) 463-3000 to terminate this authorization.
- Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.
- We do not have the ability to condition treatment, payment, enrollment or eligibility for benefits.

Within the limitations of the law, we will make every effort to accommodate your request. By law we have 30 days to complete this request, however we will make every effort to complete this in a more timely fashion.

___________________________________________________________________________
Name of Patient (Print or Type) Signature Date

___________________________________________________________________________
Signature of Patient Representative Relationship to patient /or Authority Date
Proof of □ guardianship □ power of attorney

Authorization valid for 120 days from date of signature unless revoked or terminated by the patient/ patient's personal representative.