Hayden Lake
Family Physicians
8181 Cornerstone Dr. • Hayden Lake, Idaho 83835 • Telephone (208) 772-0785 • Fax (208) 762-2704
Mark Borsheim, M.D, Terry Riske, M.D Brad Brososky, M.D. Arlie Esau, M.D Vanessa Graves, M.D Laurisa Webster, M.D
Carla Gentry, APRN, CNP Deborah Long, APRN, CNP Renee Palmer, APRN, CNP

AUTHORIZATION TO USE OF DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use of disclosure of the named individual's health information as described below:

Patient name	Date of Birth	Social Security Number
Address (street, city, state, zip code)		Telephone

The following individual or organization is authorized to make the disclosure:

☐ Hayden Lake Family Physicians
☐ Other (please specify) _____

This information may be disclosed to and used by the following individual or organization:

☐ Hayden Lake Family Physicians
☐ Other (please specify) _____

Treatment dates: Purpose of request:

The following information is to be disclosed: *(Please check one box for each item)*

yes	no	
☐	☐	physician notes
☐	☐	lab results
☐	☐	x-ray reports
☐	☐	MRI reports
☐	☐	cardiac studies
☐	☐	complete record
☐	☐	other _____

Sensitive information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome AIDS), or infection with the Human Immunodeficiendy Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

Right to revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and I understand that the revocation will not apply to information already release based on this authorization.

Other rights:

a) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need this from to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: *(If I do not specify an expiration date, event, or condition, this authorization will expire in six months.)*

Signature of patient or legal representative Date

If signed by legal representative, relationship to patient: