

Initial Point Family Medicine PLLC

To be completed by the patient or the patient's authorized representative:

Patient's Name / Patient's SSN / Patient's Date of Birth

Street Address

City State Zip Code Telephone

I hereby authorize the below referenced provider to release confidential and protected health information, as described below:
Name
Organization Name
Street Address
City State Zip Code
Telephone
Fax

I hereby authorize the following person or organization to receive this information:
Initial Point Family Medicine PLLC
2640 S. Eagle Rd
Meridian, Idaho 83642
Phone: 208-884- 0835
Fax: 208- 884-4794

This information is to be used for the following purpose(s) only:

Specific Information to released/disclosed is as follows:

- billing records - statements of charges and payments
records of treatment visits, laboratory tests and procedure results
Other

All records, or related to the period: (From) and (To)

The following items must be initialed to be included in the use or disclosure:

- AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) information
Mental health records or information
Drug / Alcohol diagnoses, treatment or referral

This authorization is valid for 180 days, unless revoked or expires on: (Expiration Date)

Notice to Patient:

When information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. You have the right to revoke the authorization in writing except to the extent that the practice has acted in reliance upon this authorization. Your written revocation must be submitted to the Privacy Officer at IPFM. You do not have to sign this authorization and that your refusal to sign will not affect your consent to use or disclosure of your protected health information for purposes of treatment, payment or health care operations. You may inspect any information disclosed under this authorization.

Patient's Signature Date

Print Patient's Name

Signature of Parent or Personal Representative Date

Print Personal Representative Name