Initial Point
FAMILY MEDICINE

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 <u>to release</u> 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 <u>receive</u> 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: _____ and _____
(From) (To)

The following items <u>must be initialed</u> 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)

<u>Notice to Patient:</u>

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