VALLEY MEDICAL CENTER, PLLC

2315 8TH STREET
LEWISTON, ID 83501
(208) 746-1383 / FAX – (208) 746-6348

Request for Release of Medical Records

Attn: Copy Clerk

PLEASE PRINT

PATIENT NAME	BIRTHDATE	**PHONE NUMBER
		( )

** PLEASE list phone number where patient may be reached.

RECORDS FROM:

____
MD or Group Name

____
Mailing Address

____
City, State & zip code

NOTE TO PROVIDER:

PLEASE ENCLOSE A COPY OF THIS RELEASE FORM WITH THE MEDICAL RECORDS YOU SEND TO VALLEY MEDICAL CENTER, PLLC

I hereby request and authorize you to furnish all the requested medical information to:

RECORDS TO:

____
MD or Group Name

____
Mailing Address

____
City, State & zip code

** APPOINTMENT DATE: ________________

→ **THE INFORMATION I REQUEST TO BE RELEASED IS:**

- ☐ ALL RECORDS
- ☐ History & Physical Exam
- ☐ Consultation
- ☐ Behavioral Health
- ☐ Progress Notes
- ☐ Mutual Exchange of Information
- ☐ EKG Reports
- ☐ Behaviors and Testings
- ☐ Other: Laboratory Reports, AIDS/HIV related data, x-ray Reports or ____

THE TIME PERIOD OF RECORDS THAT I REQUEST TO BE RELEASED IS:

☐ All Dates ☐ From _______________________ ☐to ____________________ ☐ All of School Days

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be in effect on the date notified except to the extent action has already been taken.
- I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.
- I understand that Valley Medical Center, PLLC cannot limit or control the subsequent use or dissemination of medical information by the party to whom I request the information be furnished. This request is a free and voluntary act by me. I hereby release Valley Medical Center, PLLC and its staff from all legal responsibility that may arise from the release of medical information hereby authorized.

THERE IS NO CHARGE WHEN RECORDS ARE SENT TO A PHYSICIAN FOR CONTINUING CARE. A COPYING FEE IS CHARGED WHEN RECORDS ARE RELEASED TO A PATIENT OR OTHER NON-PHYSICIAN RECIPIENT. THE COPY CHARGE IS REQUIRED CASH DAY OF SERVICE.

PARENT OR GUARDIAN: ____**DATE:** _______________
(* If patient is **13** years of age or younger.)

CONSENT OF MINOR AGED 14-17

If the patient is 14 years of age or older, only the patient may authorize the disclosure of information relating to treatment for contraception, pregnancy termination, sterilization, sexually transmitted disease, mental health conditions, alcoholism, or drug abuse. I understand that my signature below authorizes the release of this information.
* A photo-static copy of this authorization shall be considered as effective as the original.

PATIENT SIGNATURE: ____**DATE:** _______________
*** AUTHORIZATION IS VALID FOR 90 DAYS ***

PLEASE ALLOW 30 WORKING DAYS FOR COPYING AND PREPARING RECORDS