South Central Public Health District

AUTHORIZATION TO RELEASE INFORMATION

Burley Office
2311 Parke Ave., Unit 4
Burley, ID 83318
208-678-8221
Fax: 208-678-7465
WIC: 208-678-8608

Gooding Office
255 North Canyon Dr.
Gooding, ID 83330
208-934-4477
Fax: 208-934-8558

Bellevue Office
117 E. Ash St.
Bellevue, ID 83313
208-788-4335
Fax: 208-788-0098

Jerome/Shoshone Office
951 East Ave. H
Jerome, ID 83338
208-324-8838
Fax: 208-324-9554
WIC: 208-324-1323

Twin Falls Office
1020 Washington St. N.
Twin Falls, ID 83301-3156
208-737-5900
Fax: 208-736-3009

Date: _____

This document authorizes the release of medical information regarding _____
(Client's full name)

DOB: _____ to be released from: _____
(Name of Medical Provider)

_____ _____
(Street Address) (City) (State) (Zip) (Fax #)

and sent to: _____
(Name of Medical Provider)

_____ _____
(Street Address) (City) (State) (Zip) (Fax #)

I hereby authorize photocopies of any or all information requested to be released/to be furnished to the above named recipient. This release is in effect for one year from above date unless otherwise revoked. This release may be revoked at any time by a signed, written statement from the patient or responsible party.

Information to be released:

☐ All available medical records (including those received by SCPHD from other medical providers)
OR

☐ Only South Central Public Health District (SCPHD) service records to include the following:

_____ All SCPHD medical service records _____ Laboratory reports only

_____ Immunization history only _____ Other: _____

Initials _____

Is there any information you DO NOT want released?

Initials _____

SPECIFIC AUTHORIZATION

Substance Abuse Mental Health Treatment Information HIV (AIDS) Test Results

I acknowledge that data to be released MAY INCLUDE material that is protected by Federal Law. I do / do not (circle one) authorize the release of all such information.

Initials _____

-- I understand that authorizing release of this information is voluntary.
-- I understand that I may refuse to provide this authorization with no risk of it affecting my treatment or eligibility for services.
-- I understand that information obtained by this authorization might be re-disclosed and no longer protected by Federal privacy regulations.
-- I understand that SCPHD will provide me with a copy of this completed authorization upon my request.

_____ _____
Printed Name (Client or Parent/Legal Guardian) Date

_____ _____
Signature (Client or Parent/Legal Guardian) Relationship (if other than client)