Boise Natural Health Clinic
4219 W. Emerald Street, Boise, ID 83706 | office 208-338-0405 | fax 208-422-9957
www.boisenaturalhealth.com

PATIENT AUTHORIZATION FORM FOR RELEASE OF RECORDS

Patient Name: _____ Date of Birth: _____
(Please Print)

Authorizes the release/exchange of information between the following parties:

TO / FROM:

_____
_____
_____
_____

TO / FROM:

_____
4219 W. Emerald St
Boise, Idaho 83706
Fax (208) 422-9957

Specified Information Requested:

_____ Records pertaining to_____
_____ Lab/Test Results
_____ Other_____
_____ Verbal
_____ Complete records including notes and laboratory results (only if requested by provider)

Purpose for release of information:
_____

I understand that my records are protected under the Federal confidentiality regulations (42 CFR Part 164) and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

If you do not wish to release records containing information regarding diagnosis or treatment of HIV (AIDS), other sexually transmitted diseases, drug or alcohol abuse, mental illness or psychiatric treatment, please initial here_____. Unless initialed here this information is deemed permissible to release.

I hereby consent to the release of the above requested information. This consent will expire ONE YEAR after the date it is signed, or sooner at my written request.

Signature: _____ Date: _____
(Patient or legal guardian)

Witness: _____ Date: _____

Office use only
Released Date: _____ Fax or Mail: _____ by: _____