ST. JOSEPH CLINICS

St. Joseph New Patient Coordinator
504 6th Street, Lewiston, ID 83501
PHONE: 208.750.7355 FAX: 208.750.7219

Authorization to Release Medical Information

This form is to authorize that medical information regarding the below identified person be forward to St. Joseph Medical Center.

Patient name: _____ DOB: _____SS#_____

Address: _____ Phone: _____

You may use or disclose the following health care information (check all that apply):

___ All health information in my medical record.

___ Other, specify date or dates: _____

Reason for this authorization (check all that apply):

__ Transferring care to St. Joseph Regional Medical Center

__ Other (specify) _____

I'm requesting my personal health care information from:

Name (or title) and organization: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip: _____

You may disclose this information to: St. Joseph Regional Medical Center
504 6th Street, Lewiston, ID 83501
Phone: 208.750.7355 Fax: 208.750.7219

I acknowledge that date to be released may include material that is protected by Federal Law and that is applicable to drug/alcohol abuse information, mental health information, sexually transmitted disease and/or HIV/AIDS information. My signature below authorizes release of all information. I acknowledge that the above information may be sent by FAX and may be received by persons other than medical personnel and consequently, there is a risk of loss of confidentiality. I understand that information may be redisclosed by the physician or institution requesting the information is no longer protected.

This release of information authorization is valid until revoked by me, in writing, at any time. I understand that I may revoke my authorization except to the extent that St. Joseph Regional Medical Center has taken action in reliance thereon. I understand that there are ways that my health information can be disclosed without my authorization. If I would like more information of these disclosures, I understand I can request a copy of the "Notice of Privacy Practices".

_____ _____

Patient/Responsible Party: **Date of request:**

Relationship to Patient: _____