



North Canyon
MEDICAL CENTER

Authorization to Obtain/Release Medical Records

PATIENT NAME: _____ DOB: _____

ADDRESS: _____ PHONE: _____

THIS IS TO AUTHORIZE THE DESCRIBED MEDICAL RECORDS REGARDING THE ABOVE PATIENT TO BE RELEASED TO ___ OR FROM ___:

**NORTH CANYON MEDICAL CENTER
267 N CANYON DRIVE
GOODING, ID 83330
OFFICE: (208) 934-4433
FAX: (208) 934-8643**

RECORDS TO BE RELEASED FROM ___ TO ___:

FACILITY/PROVIDER/INDIVIDUAL: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____ FAX #: _____

RECORDS REQUESTED (check all that apply):

- | | | |
|---------------------|--------------------------|-------------------------|
| _____ ALL RECORDS | _____ EMERGENCY CARE | _____ URGENT CARE NOTES |
| _____ CONSULTATIONS | _____ HISTORY & PHYSICAL | _____ DISCHARGE SUMMARY |
| _____ LAB REPORTS | _____ RADIOLOGY | _____ OTHER: _____ |

THE FOLLOWING TYPES OF RECORDS REQUIRE SPECIFIC AUTHORIZATION: Each type must **be initialed** below for the request to be valid.

_____ PSYCHIATRIC NOTES _____ DRUG ADDICTION TREATMENT _____ HIV TREATMENT

THIS AUTHORIZATION IS **VALID FOR 90 DAYS** FROM THE DATE SIGNED UNLESS A DIFFERENT DATE OR EVENT IS SPECIFIED HERE: _____.

THIS AUTHORIZATION MAY BE REVOKED AT ANYTIME IN WRITING. TO REVOKE, THE PATIENT MUST SUBMIT A LETTER REQUESTING THE AUTHORIZATION BE REVOKED TO THE DIRECTOR OF HEALTH INFORMATION. RELEASING YOUR MEDICAL INFORMATION AS A RESULT OF THIS AUTHORIZATION MAY MEAN THAT YOUR MEDICAL INFORMATION COULD BE RERELEASED BY THE RECIPIENT AND NO LONGER BE PROTECTED BY FEDERAL PRIVACY RULES.

PATIENT SIGNATURE: _____ DATE: _____