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BINGHAM MEMORIAL HOSPITAL
SKILLED NURSING & REHABILITATION CENTER • IDAHO DOCTORS' HOSPITAL

Authorization for Disclosure of Health Information

_____ **Medical Record Number** **Please provide/ attach a photo ID.**

I hereby authorize Bingham Memorial Hospital to disclose the following information from the health records of:

Patient name (Last, First, Middle): _____

Previous name (Last, First, Middle): _____

Address: _____

Telephone:_____-_____-_____ Social Security No. _____-_____-_____ Birth date: _____/_____/_____

Dates of medical care: _____

To be disclosed to:

Name: _____

Street Address: _____

City, State, Zip: _____ Telephone: _____-_____-_____

Preference: ☐ Email _____ ☐ Fax _____-_____-_____ ☐ Mail ☐ Pickup ☐ USB Drive

Information to be disclosed

☐ Doctors pertinent ☐ Insurance pertinent ☐ History & physical examination

☐ Discharge summary ☐ Operative report ☐ Emergency room report

☐ Test results (please circle): EKG, Lab, Pathology, X-ray, Other: _____

☐ Other: _____

For the purpose of: _____

If requesting birth records, include mother's name at patient's time of birth:_____

I understand that this authorization extends to specific dates and services and that the "minimum necessary" information will be released to the requester, unless specified by the patient, for any and all information. Any and all information will include testing and/or treatment for sexually transmitted diseases, AIDS, or HIV infection, and alcohol and/or drug abuse or mental health conditions

I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization expires 6 months from the date listed below.

The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein

Signed _____ Date _____
Patient or legal representative & relationship

Witness _____ Date _____

The organization has up to 30 days to release records.

Patient Sticker