



**ROCKY MOUNTAIN  
Health&Wellness**

951 E. Plaza Drive Suite 110 Eagle, Idaho 83616  
Phone 208-938-5680 fax 208-938-5679

**Authorization to Disclose Medical Records**

Patient Name ..... Other Names Used .....

Current Address .....

Date of Birth ..... Phone Number ..... SSN .....

**Purpose of Release Request**

- Change Providers
- Provider Consultation
- Moving/Relocating
- Legal Reasons
- Self Use
- Other .....

**Type of Information to be released**

- Provider Notes & Records
- Imaging Reports: *Specific Date* .....
- Lab Reports: *Specific Date* .....
- Medication Record
- Entire Medical Record: *The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.*
- HIV/AIDS related records (*Must be initialed to be included in other documents*) .....
- Mental Health related records (*Must be initialed to be included in other documents*) .....
- Genetic Testing information (*Must be initialed to be included in other documents*) .....
- Drug/Alcohol diagnosis, treatment or referral information as listed on back. (*Federal Regulation, 42 CFP Part 2, requires a description of how much and what kind of information is to be disclosed. Provide a specific description of information on reverse of this form*)
- Billing Statements
- Other .....

**I Authorize information to be released FROM:**

Name of Facility.....

Address If Known.....

Phone Number ..... Fax Number .....

**I Authorize information to be released TO: (If requesting information to Self, insert personal mailing address below)**

Name of Facility.....

Name of Provider or Department .....

Address If Known.....

Phone Number ..... Fax Number .....

**Disclosure Statement & Disclaimer**

I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient without the knowledge or consent of Rocky Mountain Health & Wellness or you. This information may not be protected by Federal Privacy Regulation. Your general medication information may contain references to your mental state, drug and alcohol condition, or HIV status or sexually transmitted diseases. We make every effort to prevent release of this information; however, we cannot guarantee that every reference to these conditions has been removed from your general medical records. This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete this request.

X.....  
Signature of Patient or person authorized by law ..... Date .....

**OFFICE USE ONLY: Pick Up \_\_\_\_\_ Mail \_\_\_\_\_ Fax \_\_\_\_\_ Employees Initials \_\_\_\_\_ Date Sent \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**