Teton Valley
Health
120 E. Howard Avenue Driggs ID 83422

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name_____Date of Birth_____

Address_____Phone_____

Street City State Zip

☐ Please process this authorization now.

☐ I AUTHORIZE Teton Valley Health, Driggs or Victor Clinics to request records from:_____ on my behalf. Remit records to Fax #: 208-354-2829 or Mailing: 120 E.Howard Ave, Driggs, ID 83422. Phone # for any questions: 208-354-6350.

I AUTHORIZE Teton Valley Health ☐ Driggs Clinic ☐ Victor Clinic

TO DISCLOSE TO: _____

Address City State Zip code Fax Number

For copies of COMPLETED Medical Records, a processing fee will be charged.

The following type(s) of information per this authorization:

☐ Only the following health records from the relevant time period: ☐ Immunizations

- ☐ History & Physical
- ☐ Nurses Notes
- ☐ Pathology Report
- ☐ Physician's Progress Notes
- ☐ Emergency Room Record
- ☐ Last PO Intake
- ☐ Operative Report
- ☐ Discharge Summary
- ☐ Physician's Orders
- ☐ Consultation Report
- ☐ Radiology Reports
- ☐ Radiology Images
- ☐ EKG
- ☐ Lab Reports
- ☐ ALL

Records or Information relating to the following time period:

☐ The patient's health care between *(date)*_____and *(date)* _____

FORMAT: I would like to receive my copies of the items checked above in the following format:

- ☐ Paper Format (US Mail)
- ☐ Paper format (pickup)
- ☐ CD (TVH Images only)
- ☐ Review Only
- ☐ Fax (Healthcare Provider only)
- ☐ Secure Email _____

PATIENT ACCESS INFORMATION:

I will refer my questions regarding treatment, prognosis, or other clinical matters to my physician.

SENSITIVE NATURE RECORDS: The individual signing this authorization expressly authorizes Teton Valley Health to disclose information (diagnosis/treatment) regarding behavioral/mental health conditions (excluding psychotherapy notes), drug, alcohol, or substance abuse, HIV/AIDS, sexually transmitted diseases, communicable diseases, and genetic marker information.

I may revoke this authorization in writing at any time, except to the extent that action has already been taken to comply with it. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization expires when release is completed. I need not sign this form in order to assure treatment. I understand that once protected health information is disclosed to others. The protected health information may be disclosed to individuals or organizations not subject to the Health Insurance Portability and Accountability Act and may no longer be protected by HIPAA.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

If signed by Legal Representative, state legal relationship to patient & reason for representation. Signature of Witness

Facility Use Only:

☐ Authorizer's ID Verified ☐ ID of 3m Party Receiving Records Verified

Date released:_____/_____/_____ ☐ Info already released ☐ Needs to be released

Requesting Records: Date: _____ ☐ 2 Weeks

From: _____Phone _____ Fax _____

Address: _____City_____State_____Zip _____