Kaniksu Health Services

...providing its communities with affordable and accessible healthcare.

AUTHORIZATION TO RECEIVE AND/OR RELEASE PROTECTED HEALTH INFORMATION

PATIENT INFORMATION				
Last Name:	First Name:	Middle Name:		
Birth Date:	Social Security #			
Phone #:				
Address:	City:	State:	Zip:	

I request and authorize Kaniksu Health Services (fax: 208-263-7198 or _____, P.O. Box 2160, Sandpoint, ID 83864) to

☐ **Release To:** ☐ **Obtain From:**

Organization or Person:		
Address:		
City/State/Zip:	Phone:	Fax:

☐ Medical/Dental records from the most recent two years. **Includes sensitive information (as consented to below).

OR

☐ Medical/Dental records from date:_____to date:_____. **Includes sensitive information (as consented to below).

OR

Specific records (checked below), from date: _____ to date: _____

☐ Immunizations
☐ Medication List
☐ X-Ray/Diagnostic Imaging
☐ Other _____
☐ Billing Records
☐ Chart Notes
☐ Lab Results (Specify: _____)

Disclosure Method

☐ Fax Records ☐ Electronically Transmit Records ☐ Pick Up Paper Records ☐ Mail Paper Records

Are you transferring care to another Provider/Entity?: ☐ No ☐ Yes

****Sensitive Information (Requires Your Consent to Disclose - Check any/all that you consent to disclose).**

☐ HIV/AIDS Related Records
☐ Birth Control/Pregnancy Records
☐ Mental Health Records
☐ Sexually Transmitted Disease Records
☐ Drug/Alcohol Abuse Diagnosis/Records
☐ Genetic Testing Records

Patient may revoke this authorization at any time prior to expiration by notifying Kaniksu Health Services in writing. Unless revoked earlier, this authorization will expire 1 year from the date of signing. I understand that I may refuse to sign this authorization, and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by federal privacy laws or regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations. I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

_____ _____ _____

Signature **Parent/Guardian (if minor)** **Date**

Office Use Only

Identity of Patient verified with: ☐ Photo ID ☐ Other:_____

Verified by: _____ Date: _____

Request Completed By: _____ Date: _____