213 N. Main St, Moscow, ID 83843 Telephone: 208-882-7565 Fax: 208-882-7567

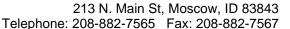


Authorization to Release Protected Health Information

Patient Name:		Date of Birth:		
Previo	ous Name			
	nay disclose this health car			
To:	Moscow Medical, P.A.	From:		
-	·	P: F:		
F:	208-882-7567	P: F:		
	information and services (and older); other infection reported to local health of	s signature is required in order to disclose information related to birth control (at any age); sexually transmitted diseases (if age 14 and older); HIV/AIDS (if age 14 us, contagious, or communicable disease required under applicable law to be fficials (if age 14 and older); drug and/or alcohol abuse (if age 14 and older); and liness services (if age 14 and older).		
l.	My Authorization Mossay Medical R.A. may use as disclose the following health care information (shock all that apply).			
	Moscow Medical, P.A., may use or disclose the following health care information (check all that apply): All health care information in my medical record			
	Health care information in my medical record relating to the following treatment or condition:			
	realist care information in my measure reading to the following treatment of conditions			
	 Health care informati 	Health care information in my medical record for the date(s):		
	Other (e.g., X-rays, bills)—specify date(s):			
	Uses and Disclosures Requiring Specific Authorization You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):			
	□ HIV/AIDS	□ Sexually transmitted diseases		
	Mental health or illneBirth control informat	3 ,		
	□ Birth control information and services (minors only)			
	Reason(s) for this authorization to use or disclose my health care information (check all that apply):			
	□ at my request			
	□ other (specify)			
	This coal coincides			
	This authorization ends: on (date): or when the following event occurs:			
		ent is not specified above, this authorization ends 6 months after the date signed.		
	ii aii expiration date of ev	ent is not specified above, this authorization ends o months after the date signe		

II. My Rights

- 1. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits). However, I do have to sign an authorization form:
 - to receive research-related treatment in connection with research studies or
 - to receive health care when the purpose is to create health care information for a third party.





2. I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by **Moscow Medical, P.A.,** in reliance on this authorization before it receives my written revocation. I may not be able to revoke this authorization if its purpose was to obtain insurance.

To revoke this authorization:

- Write a letter to Moscow Medical, P.A.
- **III. Protection after Disclosure**. I understand that once my health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer protect it.

Patient or legally authorized individual signature	Date
Printed name (if signed on behalf of the patient) representative)	Relationship (parent, legal guardian, personal
Minor patient's signature, if applicable	Date

*** We DO NOT accept records on CDs or thumb drives *** When records are over 50 pages they must be mailed.

^{*} If the authorization is for use or disclosure of PHI for research where research-related treatment is conditioned upon the individual's authorization to use or disclose PHI for the research, and the individual also has the unconditional choice to authorize use or disclosure of PHI for other research activities, this form should not be used. Use the Combined Authorization to Use or Disclose Protected Health Information for Research form.