MOSCOW MEDICAL
where you matter

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: _____

Previous Name: _____

You may disclose this health care information:

To: Moscow Medical, P.A. From: _____

F: 208-882-7567 P: _____ F: _____

Minors – a minor patient's signature is required in order to disclose information related to birth control information and services (at any age); sexually transmitted diseases (if age 14 and older); HIV/AIDS (if age 14 and older); other infectious, contagious, or communicable disease required under applicable law to be reported to local health officials (if age 14 and older); drug and/or alcohol abuse (if age 14 and older); and certain mental health or illness services (if age 14 and older).

I. My Authorization

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: _____
- □ 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 illness
- □ Drug and/or alcohol abuse
- □ 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 authorization ends:

□ on (date): _____ or when the following event occurs: _____

If an expiration date or event is not specified above, this authorization ends 6 months after the date signed.

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.

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

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) Relationship (parent, legal guardian, personal representative)

_____

Minor patient's signature, if applicable Date

* 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.

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