

**INTERMOUNTAIN MEDICAL CLINIC**  
1951 BENCH RD, STE B—Pocatello, ID 83201 -- PHONE 238-1000 – FAX 238-0009  
**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

PATIENT NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

PATIENT ADDRESS: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

I am requesting: \_\_\_\_\_ Access to \_\_\_\_\_ Copy of

- |   |                          |
|---|--------------------------|
| _____ The entire medical record                     | _____ Laboratory reports |
| _____ Most recent five-year history                 | _____ Pathology reports  |
| _____ Medical records needed for continuity of care | _____ X-ray reports      |
| _____ Billing statements                            | _____ Immunizations      |
| _____ Other (please specify) _____                  |                          |

**\* The following items must be initialed to NOT BE included in the use or disclosure of other health information:**

- \_\_\_\_\_ \*HIV / AIDS related health information and/or records
- \_\_\_\_\_ \*Mental health information and/or records
- \_\_\_\_\_ \*Genetic testing information and/or records
- \_\_\_\_\_ \*Drug/alcohol diagnosis, treatment and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.)
- \_\_\_\_\_ \***Psychotherapy notes** (If this authorization is for the use and/or disclosure of psychotherapy notes, then it cannot be combined with any other authorization.)

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to **Family Practice Group, P.A.** Unless revoked earlier, this authorization will expire 180 days 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 redisclosed and no longer protected by these 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 of Individual or Individual's Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Legal Representative (if applicable)

\_\_\_\_\_  
Relationship of Legal Representative

**Request for access or copy is**    Accepted    Denied

If denied, check the following reason for denial:

- PHI is not part of the patient's designated record set.
- Federal law forbids making the requested information available to the patient for inspection (eg/ CLIA or Privacy Act of 1974).
- The requested information is psychotherapy notes.
- The requested information has been compiled for legal proceeding.
- The requested information was obtained under promise of confidentiality and access would be reasonably likely to reveal the source of the information.
- The requested information is temporarily unavailable because the individual is a research participant.
- Licensed health care provider has determined that access to the requested information would result in physical harm to the individual or others.
- Licensed health care provider has determined that the requested information identifies a third person who may be physically, emotionally, or psychologically harmed if access to the information is granted.
- Licensed health care provider has determined that access to the requested information by the patient's legal representative could result in harm to the individual.
- We are acting under the direction of a correctional institution and letting the inmate access or obtain a copy of the requested information would jeopardize the health, safety, security, custody, or rehabilitation of another person at the correctional institution.
- The requested information is not maintained by our facility.

**RIGHT TO REVIEW:**

You    do    do not   have the right to a review of this denial.

Contact Information : \_\_\_\_\_

You do have a right to complain to the Secretary of the Department of Health and Human Services. Please see the enclosed information.

Staff Comments

\_\_\_\_\_  
\_\_\_\_\_

**METHOD BY WHICH HEALTH INFORMATION WAS DELIVERED:**

Mail                       In-person                      **DATE:** \_\_\_\_\_  
 Electronic means    Other \_\_\_\_\_

\_\_\_\_\_  
Employee who prepared requested information

\_\_\_\_\_  
Date