Authorization to Release Medical Information

Boise Vision Care

3293 N Milwaukee St
Boise, ID 83704
P: 208-322-2020 F: 208-322-1192

IMPORTANT PLEASE READ: This form authorizes your health care provider to release health information regarding your care of treatment to the individual or organization you identify as set out below:

Patient Information

Patient Name: _____

DOB: _____/_____/_____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

I hereby authorize Boise Vision Care to: (check one)

[ ] **Provide** records to: _____

_____

P:_____ F:_____

[ ] **Obtain** records from the entity listed below:

Purpose of the Request:

[ ] At request of patient or patient representative

[ ] Other: _____

_____

Records to be released from: [ ] Boise Vision Care [ ] Entity Listed Below

Office: _____

Address: _____

Phone: _____ Fax: _____

Fax: _____

I understand this release may include disclosure of information relating to treatment for alcohol/substance abuse, human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), sexually transmitted disease (STD), or for psychiatric treatment or counseling, unless I specify otherwise below:

Please do not release any information concerning treatment for the following: _____

_____

I UNDERSTAND THIS AUTHORIZATION MAY BE REVOKED AT ANY TIME EXCEPT TO THE EXTENT ACTION HAS BEEN TAKEN BASED UPON IT. THIS AUTHORIZATION WILL EXPIRE IN 60 DAYS FROM THE DATE SIGNED UNLESS OTHERWISE SPECIFIED: _____

Information used or disclosed because of this authorization may be further disclosed by the recipient and therefore no longer protected.

Date: _____ Signature: _____

Signature: _____ / _____

If patient unable to sign: _____ / _____