



RELEASE OF SHC MEDICAL RECORDS TO OTHERS

607 West Main • Grangeville, ID 83530 • 208-983-1700 • www.syringahospital.org

Patient Name _____ Date of Birth _____ SS# _____

Address: _____ Phone _____

This release authorizes the described medical records regarding the above patient to be released by:

Syringa Hospital 607 W Main St Grangeville, ID 8353	Syringa Hospital FP Clinic 607 West Main St, Grangeville, ID 83530	Syringa Hospital Kooskia Clinic Kooskia, ID 83539	Syringa Women's Health Center 607 W Main St Grangeville ID 83530
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Records to be released to: _____

Address _____ Phone _____

Contact Person _____ Dates of service to include: _____

Purpose or need: _____

Information requested (check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> All hospital records | <input type="checkbox"/> Laboratory reports | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> X-ray Reports | <input type="checkbox"/> Emergency Record |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Pathology reports | <input type="checkbox"/> Clinic record |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Physician Orders | <input type="checkbox"/> Billing statements |
| | | <input type="checkbox"/> Other: _____ |

* The following items must be **initialed** to be included in the use and/or disclosure of other health information:

- | | |
|--|---|
| _____ *HIV/AIDS related information and/or records | _____ *Mental health information and/or records |
| _____ *Genetic testing information and/or records | _____ *Drug/alcohol diagnosis, treatment or referral info |
- (Federal regulations require a description of how much and what kind of information is to be disclosed.)

Describe: _____

I understand that information disclosed per this authorization may be subject to re-disclosure and no longer protected.

I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire 6 months from the date of signing.

Signature of Patient (or Patient's Legal Representative if applicable) _____ Date _____

Print Patient's Name (or Patient's Legal Representative if applicable) _____ Relationship to Patient _____

**** NOTE: To protect against identity theft photo and signature ID must be provided with this Authorization.**

NOTICE TO RECIPIENT OF INFORMATION: This information has been disclosed to you from records the confidentiality of which may be protected by Federal and/or State Law. If the records are so protected, Federal regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT