CONSENT TO RELEASE MEDICAL RECORDS

Patient Name: ______________________________ Date of Birth: ______________

I give consent for my medical information to be released.

TO:
____
____
____
____

FROM:
Sinus Center Idaho/Allergy Clinic Idaho
3085 E Magic View Dr.
Meridian, ID 83642
(P) 208-433-9300 (F) 208-433-9854

PLEASE SEND THE FOLLOWING RECORDS:

________ Office Notes
________ CT Report
________ Lab Report(s)
________ Operative Report
________ Pathology
________ CT Disc - Please indicate format
___ Dicom OR ___ Viewer

PURPOSE FOR MEDICAL RECORDS:

________ Primary Care Physician
________ Second Opinion
________ Other: ____
________ Transfer to another M.D.
________ Moving out of the area

EXPIRATION OF CONSENT:
This consent will expire:
[ ] after a one time release of information
[ ] as of this date ____________________
[ ] other __________________________

I understand that I have the right to revoke this consent in writing at any time. I understand that I will be responsible for fees associated with records requested for personal purposes. Records will be provided to other health care providers at no charge. Exceptions to revoking this consent are (1) this facility has already acted on the initial consent prior to my revocation and (2) consent was obtained as a condition of obtaining insurance coverage. Sinus Center Idaho/ Allergy Clinic Idaho cannot condition treatment or eligibility of benefits on whether the authorization is signed. I also understand that the information disclosed to the person or entity indicated above may be subject to re-disclosure by the recipient and is no longer protected by the privacy standards of this facility.

SIGNED: ____ DATE: ______________

RELATIONSHIP TO PATIENT: ________________________

WITNESS: ____ DATE: ______________