



AUTHORIZATION OF USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

- 215 E. Hawaii Ave. Nampa, ID 83686 208 463-3229 Fax: 208 465-4825
4400 E. Flamingo Ave Nampa, ID 83687 208 463-3229 Fax: 208 465-4825
3277 E. Louise Dr. Meridian, ID 83642 208 463-3229 Fax: 208 465-4825
1818 S. 10th Suite 220 Caldwell, ID 83605 208 463-3329 Fax: 208 465-4825
7272 Potomac Ave. Boise, ID 83702 (208) 884-2922 (208) 884-2923

REQUEST TO COPY PROTECTED HEALTH INFORMATION

Patient's Name (Type or Print) Phone Number Date of Birth

Full Address

Please Obtain Information From:

Please Send Information To:

Request for Medical Information
From Business Name:
From Doctor:
Address:
City/State Zip
Phone:
Fax:

Authorization to Release Medical Information
Send to:
Address:
City/State Zip
Phone:
Fax:

Purpose of Release: (The reason I am authorizing release.)
My request To provide my health information to another provider Other

Information to be Used or Disclosed

- Complete health record Substance Abuse Hospital Reports Other
History & Physical / Progress Notes X-ray film images Complete billing records
Laboratory test results X-ray reports HIV/AIDS
Consultation Reports Test results Photographs

Date(s) of service:
The information covered by this authorization includes the information checked in the above paragraph:
(Please write any additional requests here)

- Pick-Up Records Mail Records Fax Records

- Exclusions: Psychotherapy Notes Information related to legal proceedings Information not included in your Medical Record You are a prison/correctional inmate... Information that federal or state laws prevent us from disclosing

ADDITIONAL INFORMATION
You may revoke or terminate this authorization by submitting a written revocation to Saltzer Medical Group. You should contact the HIPAA Privacy Officer at (208) 463-3000 to terminate this authorization.
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Within the limitations of the law, we will make every effort to accommodate your request. By law we have 30 days to complete this request, however we will make every effort to complete this in a more timely fashion.

Name of Patient (Print or Type) Signature Date

Signature of Patient Representative Relationship to patient /or Authority Date
Proof of guardianship power of attorney

Authorization valid for 120 days from date of signature unless revoked or terminated by the patient/ patient's personal representative.