PHONE: (208) 336-1300 | FAX: (208) 429-1410

3858 N. Garden Way, Suite 202, Boise, ID 83703

Authorization to **Release/Request Medical Information and/or Medical Records**

____ ________/______/________

Patient's Full Name **Date of Birth**

The undersigned is the patient or legally authorized patient's representative. I authorize The Well Office, LLC to use or disclose Protected Health Information (PHI) contained in my medical records in the following manner:

From:____

Physician/Institution that presently has the information

____

Street Address

____

City State Zip Code Phone Fax

To: ____

Physician/Institution that is requesting the information

____

Street Address

____

City State Zip Code Phone Fax

Release the following PHI: ⑦ ***All Records*** ⑦ ***Laboratory Results***

⑦ ***Chart Notes*** ⑦ ***Medications/Medication Log*** ⑦ ***Verbal Coordination***

⑦ ***Other (please specify):*** ____

This authorization is in full force and effect until** <u>1 year from the date of signature</u> **or until revoked or terminated by the patient or the patient's personal representative. You may revoke or terminate this authorization by submitting a written revocation to The Well Office, LLC.

- I understand that when I revoke this authorization, it is not effective to extend that The Well Office, LLC has already relied on the use or disclosure of the PHI.
- I understand the PHI released pursuant to this authorization might be re-disclosed by the party who receives the information and may no longer be protected by federal or state law.
- The Well Office, LLC will not base my treatment or payment on whether I provide an authorization for the requested use or party (such as an exam for work).
- I understand that I have a right to inspect or copy the PHI to be used or disclosed.
- I understand that I have a right to refuse to sign this authorization.
- If you have any questions concerning this form, please contact office administrator.

____

Signature or Patient, Personal Representative, or Parent/Guardian **Date**