Endobiogenic Integrative Medical Center (EIMC)
in cooperation with
Idaho State University Integrative Health Clinic
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Authorization for the Release/Disclosure of Protected Health Information

I authorize			
Address			
Phone		Fax:	

To release information and/or copies of medical records for the following patient:

Patient Name:						DOB:	
SS#:		Address:					
City:		State:		Zip:		Phone:	

Description of information to be released	❑ Office Notes; ❑ Pathology Reports; ❑ Laboratory Reports;
❑ PAP Smear Reports; ❑ Procedure Records; ❑ Hospital Records; ❑ Consultation; ❑ X-ray Reports; ❑ MRI/CT Reports;	
❑ Ultrasound Reports; ❑ Complete Medical Record; ❑ Other (Please Specify):	
Comments:	
Please specify the dates of records to be released:	
Purpose of Disclosure	❑ Continuity of care; ❑ Legal; ❑ Patient Request; ❑ Other (Describe):

I understand that my medical records (PHI) may contain information pertaining to treatment for psychiatric illness, substance abuse, or the HIV virus. I hereby consent to the release of this information.

I authorize records to be sent to:	From:

This authorization is valid for 90 days from the date set forth below opposite my signature. It may be revoked at any time in writing prior to the expiration of such 90-day period. Revocation of this authorization shall not affect releases made prior to the revocation.

Endobiogenic Integrative Medical Center will not condition treatment on whether or not you sign this form.

After your protected health information (PHI)/medical records are released by your authorization, the possibility exists that your PHI will no longer be subject to the protection of federal privacy regulations and may be re-disclosed by the recipient.

I certify that I have the authority to approve the requested release of information and sign this authorization.

Signature of patient or patient representative	Date
Print name or personal representative	Representatives relationship to patient