

STUDENT HEALTH CLINIC

Moscow Family Medicine, P.A.
831 Ash Street, Moscow, ID 83844-4201
Tel: (208) 885-6693 Fax (208) 885-5354

Request for Release of Medical Records

Records From:

Student Health Clinic - Moscow Family Medicine, P.A.

MD or Group Name

831 Ash Street, University of Idaho Campus

Mailing Address

Moscow, ID 83844-4201

City, State, & Zip Code

Records To:

MD or Group Name

Mailing Address

City, State, & Zip Code

I hereby request and authorize the release of requested health care information from the above-named party to the corresponding above-named party. This authorization will expire one year from the date signed below, unless I revoke it earlier. I can revoke it by signing a corresponding revocation of authority. I understand that information I authorize to be released may be subject to redisclosure by the recipient.

The information that I request to be released is:

- ALL RECORDS
- Progress Notes
- Laboratory Results
- AIDS/HIV/STD Info
- History & Physical Exam
- Imaging Reports
- Psychotherapy notes** _____
Initial
- Delivery Notes
- EKG reports
- Other _____

The time period of records I request to be released includes:

- ALL DATES
- From _____ to _____

I authorize the release of information as described above. I understand that there may be a charge for this service, and I agree to pay said charge on demand. This authorization will expire one year from the date signed below, unless I revoke it earlier. I can revoke it by signing a corresponding revocation of authority. I understand that information I authorize to be released may be subject to redisclosure by the recipient.

Patient or Guardian

Date

If guardian, relationship

Minor Aged 14-17

If the patient is aged 14 years or older, only the patient may authorize release and/or disclosure of information related to sexually transmitted disease. I understand that my signature below authorizes release of this information. Authorization is valid for 1 year unless revoked earlier, and I can revoke this authorization by signing a corresponding revocation of authority. I understand that information I authorize to be released may be subject to redisclosure by the recipient.

Patient / Date

Patient Information:

Name: _____

Other (maiden) name: _____

Birth date: _____

SSN#: _____

Please Print