Patient ID #_____

Authorization to Allow Access to Medical Information

Patient Information: Name: _____

Birthdate: _____ Age: _____

SSN#:_____ Cell Phone#:_____

If you do not wish to authorize access of your medical information to anyone initial here:_____

Provide My Medical Information Upon Request To:

Name	Date of Birth	Phone Number	Relationship to Patient

If you would like to enroll in our secure Patient Portal to have access to your own medical information online, please provide your email address:

Email Address: _____

How would you like to receive appointment reminders? Text ☐ Email ☐

****Family portal accounts also available, please see a Patient Service Representative at the front desk****

I understand the information I authorize to be released may include STD's, HIV, Mental Health and/or drug/alcohol information. **The information that I request to be released is:**

- ❒ **ALL RECORDS**
- ❒ **EXCLUDING:**

_____

I authorize the release of information as described above from Catalyst Medical Group Moscow Family Medicine division. This authorization will not expire and must be revoked by me. I can revoke it or change it at any time by signing a new authorization form. I understand that information I authorize to be released may be subject to re-disclosure by the recipient.

_____

Patient or Guardian Signature **Date**

Relationship to Patient _____

If the patient is aged 14 years or older, only the patient may authorize release of confidential information relating to sexual behaviors, mental health, drug and/or alcohol usage. I can revoke or change this authorization by signing a new request of access form. I understand that information I authorize to be released may be subject to re-disclosure by the recipient.

_____ _____

Minor Aged 14-17 Signature **Date**

Consent Given_____ Declined_____

Patient ID #_____

Acknowledgment of Receipt of Notice of Health Information Practices

I have been offered a copy of Catalyst Medical Group Moscow Family Medicine division's Notice of Health Information Practices, which describes how my health information is used and shared. I understand that Catalyst Medical Group Moscow Family Medicine division has the right to change this notice at any time. I may obtain a current copy by asking a receptionist, or by visiting Catalyst Medical Group Moscow Family Medicine division's website at www.MoscowFamilyMedicine.com

Acknowledgement of Receipt of Financial Policy

I have received and reviewed a copy of Catalyst Medical Group Moscow Family Medicine division's Financial Policy, which explains their policy on fee collections for services rendered. I understand that Catalyst Medical Group Moscow Family Medicine division has the right to change this notice at any time. I may obtain a current copy anytime by asking a receptionist, or by visiting Catalyst Medical Group Moscow Family Medicine division's website at www.MoscowFamilyMedicine.com.

Attention University of Idaho students All unpaid balances for services provided at the Student Health Services clinic will be transferred to your student account and will be due to the University of Idaho.

_____ _____

Patient Name (Printed) Date of Birth

_____ _____

Signature Date Relationship (if signed by other than patient)