Please return completed form with a copy of **Identification to:
BONNER GENERAL HEALTH • Attn: Health Information • 520 N Third Ave. • Sandpoint, ID 83864 or
FAX to: (208) 263-1644

MR# ___________________

Authorization for Release Of Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name ____ **Date of Birth** __________________

I hereby authorize Bonner General Health to release my individually identifiable health information to (specify individual/organization and address): ____

____

Specific description of information requested (including date[s]):____

____

________ (Initials) ☐ I DO ☐ I DO NOT consent to release of information relating to psychiatric or psychological testing or treatment, alcohol and/or drug abuse diagnosis, prognosis and treatment and/or HIV (AIDS) testing and/or results, or such disclosure shall be limited to the following specific types of information: ___________________________

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on ____/____/____ (MM/DD/YR) or 90 days after signed.
   Initials________
2. I understand that I may revoke this authorization at any time by notifying Bonner General Health in writing, but if I do it will not have any affect on any actions Bonner General Health took before they received the revocation.
   Initials________

____ ___________________________

Signature of patient or patient's representative **Date**
(Form MUST be completed before signing)

____ ________________________________

Printed name of patient's representative: Relationship to patient

**Authorized representative must submit copies of legal document supporting his or her authority to act on the patient's behalf.*

☐ Verified with Photo ID/Driver License

Electronic records will be provided upon request.

A copy or facsimile (fax) of this authorization is as valid as the original.

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Health Information copies are provided free of charge for Continued Care.

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CRF part 2) prohibit you from making further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for release of medical or other information if held by another party is NOT sufficient for this purpose.

/consent