Boise Dermatology
3109 S. Meridian Road
Meridian, ID 83642-7088
Phone: 208.888.0660 Fax: 208-567-5973

Authorization for Release of Protected Health Information
To be completed by the patient or the patient's authorized legal representative:

_____ _____ _____
Patient's Name Date of Birth Telephone

_____ _____ _____ _____
Street Address City State Zip

To or From: _____ _____
(Circle One) Fax #

_____
Address

_____ _____
City State Zip Phone #

____ All records related to: _____
(Please indicate if there is a specific condition or if all records for the patient.)

____ All Records from _____ to _____

If you do not wish to release records containing information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted disease, drug and/or alcohol abuse, mental illness or psychiatric, please initial here _____

Unless initialed here this information is deemed permissible to release.

This authorization is valid for 180 days.

Notice to Patient:
When information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. You have the right to revoke the authorization in writing except to the extent that the practice has acted in reliance upon this authorization. Your written revocation must be submitted to the Privacy Officer at Boise Dermatology. You do not have to sign this authorization and your refusal to sign will not affect your consent to use or disclosure of your protected health information for purposes of treatment, payment or health care operations. Photocopies, facsimile or scan of this Authorization shall be considered to be the same as a signed original.

_____ _____
Patient's Signature Date

_____ _____
Printed Name of Personal Representative or Legal Guardian Date

_____ _____
Signature of Parent or Personal Representative or Legal Guardian Date