AUTHORIZATION TO VERBALLY USE OR DISCLOSE PROTECTED HEALTH INFORMATION TO THIRD PARTY

By signing this authorization, I authorize Full Circle Health to verbally disclose certain protected health information (PHI) about me to the person named below for the purpose of coordinating my care with scheduling, nursing, and provider staff. Specifically, the following information may be verbally discussed with the authorized individual: (Select all that apply.)

[ ] Office visits
[ ] Charges, payments, billing information
[ ] X-ray reports and other images
[ ] Lab tests/results
[ ] AIDS/HIV information:
[ ] Consultation reports
[ ] Pathology tests/results
[ ] Complete chart
[ ] Other _____

_____
Name of person who may receive your PHI

_____
Relationship to Patient

_____
Phone Number

This authorization will expire on: _____. (Expiration Date or Defined Event. If no date indicated, this authorization will expire one year from the date it was signed.)

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the person who receives it and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Full Circle Health acted in reliance upon this authorization. My written revocation must be submitted to Family Medicine Residency of Idaho's Privacy Officer at 777 N. Raymond St., Boise, ID 83704. I understand that Full Circle Health may not condition patient's healthcare on this authorization unless the purpose for provider's evaluation and treatment is to disclose information consistent with this authorization.

_____
Print name of patient whose PHI may be released

_____
Date of Birth or Social Security #

Signed by: _____
Signature of Patient or Legal Guardian

_____
Relationship to Patient

_____
Date

FOR INTERNAL USE ONLY

Date Request Received _____