AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient First and Last Name: ____
Date of Birth: ____________________ Address: ______________________________
Telephone: ______________________ Email Address: ____________________________
Other names under which the Patient has been treated: ________________________

I Authorize:
Name: Full Circle Health
Address: 777 N Raymond St. Boise, ID 83704
Telephone: (208) 514-2500 Fax: (208) 375-2217

[ ] To **release** my confidential health information to: [ ] To **request** my confidential health information from:
Name: ____
Address: ____
Telephone: ______________________ Fax: ____________________________
[ ] Patient pick up paper copies [ ] Patient Portal/ MyChart [ ] Records on a Flash Drive [ ] Copies by Fax

For the following purpose: (check one or more)
[ ] to provide treatment [ ] coordination of care [ ] at the request of the patient
[ ] marketing/fundraising [ ] transferring care [ ] Other ____________________

I authorize PROVIDER and its employees, agents, or associated healthcare practioners to use or disclose the Patient's protected health information as described below.
[ ] Office visits [ ] Accounting of visits [ ] X-Ray reports and other images
[ ] Consultation reports [ ] Pathology tests [ ] Complete patient chart
[ ] Lab tests [ ] Charges, payments, billing information [ ] Other ____________________
[ ] Mental Health/Counseling Notes

Healthcare provided between (date): ____________________ and (date): ____________________
This authorization will expire on the following date or event: ____________________. If no specific date or event is stated, this authorization will expire one (1) year from the date of this authorization.

- I understand that I have the right to revoke this authorization at any time except to the extent that PROVIDER has taken action in reliance on this authorization. To revoke this authorization, I must submit a written revocation to:
  Full Circle Health: 777 N Raymond St. Boise, ID 83704
- I understand that PROVIDER may not condition the Patient's healthcare on this authorization unless the purpose for PROVIDER's evaluation is to obtain and disclose information to entities consistent with this authorization, the Patient is involved in research-related treatment and use, or disclosure is for such research.
- I understand that information disclosed by PROVIDER pursuant to the authorization may be re-disclosed by the entity that receives this information and may no longer be protected by privacy regulations.
- I understand I may be charged if more than 15 pages are copied, and that payment is due prior to release of records.

______________________________ ______________________________
Electronic Signature Date

____
Authority or relationship to the Patient

For Office Staff Only
Received: ______________
Processed: ______________
Amount: $ ______________