NORTH IDAHO MEMORY CLINIC

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AUTHORIZATION FOR NORTH IDAHO MEMORY CLINIC, TO OBTAIN, USE OR DISCLOSE MY HEALTH INFORMATION

Patient name: _____ Date of birth: _____
Previous name: _____ SSN: _____

I. My Authorization: By initialing the spaces below, I specifically authorize the use or disclose the following health care information and/or records (initial all that apply):

____ All my health information ____Laboratory and/or Pathology Reports Only ____Most recent 2 year history
____My health information for the date(s): _____ ____ Medication List
____My health information relating to the following treatment or condition: _____
____Other: _____

The following items must be initialed to be included in the use or disclosure of other health information:

_____HIV/AIDS related health information and/or records _____Sexually Transmitted Disease Information and/or records
_____Mental Health Information and/or records _____ Genetic testing information and/or records
_____Drug/Alcohol diagnosis, treatment and/or referral information

(Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.)

You may __Disclose, __Obtain and Use, and/or __Exchange this health information to/from: CHECK ALL THAT APPLY

Name (or title) and organization_____
Address: _____City _____State _____Zip_____
Phone #:_____ May we transmit your records via fax? __Yes __No Fax #:_____

Reason(s) for this authorization (check all that apply):

☐ at my request ☐ other (specify) _____

This authorization ends: ☐ on (date) _____ ☐ No Date Restrictions

Or ☐ when the following event occurs _____

II. My Rights: I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by **North Idaho Memory Clinic** based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. The way to revoke this authorization is:

- Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____ _____
Patient or legally authorized individual signature Date Time

_____ _____
Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, etc)

_____
Witness

FOR OFFICE USE ONLY:
DATE RECEIVED: _____ PROVIDER APPROVED_____OR PROVIDER DENIED_____ (Initial & Date)
IF DENIED, REASON: _____
HEALTH INFORMATION SENT: _____
SENT VIA MAIL/FAX/OTHER: _____ DATE PROCESSED: _____ROCESSED BY STAFF: _____