2199 N. Merritt Creek Loop
Coeur d'Alene, ID 83814

niderm.com

Medical 208.665.7546
Spa 208.292.5939
Fax 208.667.4607
E: mr@niderm.com

Authorization to Release Healthcare Information

*** Some requests may be subject to a $10.00 charge with 10 cents per page for copying complete records***

Patient Name: ____
(Last) (First) (Middle Initial)

Birth Date: ________________ SSN#: ________________ Phone: ________________

Release From: ________________ Release To: ________________

________________ ________________

________________ ________________

Phone: ________________ Phone: ________________

Fax: ________________ Fax: ________________

Please check on the following options:

{ } Patient will pick up and hand carry records

{ } North Idaho Dermatology will **mail** records to the individuals or organization above

{ } North Idaho Dermatology will **fax** records to the individuals or organization above

{ } The individual or organization above will mail or fax records to North Idaho Dermatology

Information to be released:

{ } All Medical Records

{ } All Dermatological Records

{ } Pathology/Laboratory

{ } Other ____

Exceptions (if any): See discolsure statement below

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For the purpose of:

{ } Transfer of Medical Care { } Billing Purposes { } Legal Matters { } Personal { } Continued Care

Turn Over

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I understand that authorizing the use of disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I authorize the use and disclosure of my entire patient file including any information that I might consider sensitive such as mental health, sexually transmitted diseases, alcohol/drug abuse treatment, HIV/AIDS related treatment, etc. If there are certain parts of my medical record I do not want disclosed, I have written those exceptions on this form in the space above. I hereby release the Supplier and its staff from all legal responsibility that may arise from the release of the medical information hereby authorized. I understand that once the above information is disclosed, the information may not be protected by federal privacy law sand may potentially be disclosed by the recipient.
REVOCATION: I understand that I may revoke this authorization at any time by notifying the Health information Management Department at North Idaho Dermatology in writing and by completing the REVOCATION OF AUTHORIZATION form. I understand that the revocation will not apply to information that has already been released in response to this authorization.
EXPIRATION: This authorization will expire in 6 months from date of signature
Please allow 7-10 business days for processing.

Printed Name of Patient or Guardian: ______________________ Date: __________

Signature of Patient or Guardian: ______________________ Date: __________

For Office Use Only

Signature of Person Releasing: ______________________ Date: __________

☐ Mailed: ______________ initial/date

☐ Faxed: ______________ initial/date