GRAND PEAKS
MEDICAL • PHARMACY
DENTAL • BEHAVIORAL HEALTH

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:	***Date of Birth:***

I authorize (Provider name or Facility)_____

Address: _____Phone #:_____Fax#:_____

To provide my healthcare information via FAX to:
Grand Peaks Medical Dental Behavioral Health or Pharmacy (Upper Valley Community Health Services, Inc.)
Ph. (208) 356-4900, at the following location(s):
Rexburg Location: 72 S 1st E, Rexburg, ID 83440
❑ Medical Fax (208) 356-3724 ❑ Dental Fax (208) 359-1600 ❑ Behavioral Health Fax (208) 624-4030
St. Anthony Medical, Behavioral Health and Pharmacy Locations: 335 E Main St., St. Anthony, ID 83445
❑ Medical Fax (208) 624-4116 ❑ Behavioral Fax (208) 624-4030 ❑ Pharmacy Fax (208) 624-4114
St. Anthony Dental Location: 325 E Main St., St. Anthony, ID 83445
❑ Dental Fax (208) 624-4117

To release the health information specified below:

❑ Entire medical record including patient healthcare history, office notes (except psychotherapy notes), test results, radiology studies, referrals, consultations, billing records, insurance records and records sent by other healthcare providers.
❑ Medical records from (Date)_____ to (Date)_____
❑ Description of information to be released: _____
_____

Purpose: ❑ Continuity of Care ❑ Self ❑ Other _____

TO BE READ AND SIGNED BY THE PATIENT:

I UNDERSTAND THE FOLLOWING:

- I may revoke this authorization at any time by providing written notice to the practice.
- I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
- I understand that if I refuse to sign this disclosure, it will not affect my ability to obtain treatment.
- I understand that I may inspect or copy any information to be used or disclosed under this authorization.
- I understand that if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by federal privacy laws or regulations.
- I understand federal regulations require a description of how much and what kind of information is to be disclosed. Information relating to drug and alcohol abuse, confidential HIV related information and mental health treatment (except psychotherapy notes) will only be disclosed if stated above in the description.
- Please allow 30 business days for records to be prepared. There may be a charge for these services.
- *This authorization expires 1 year from the date signed unless terminated in writing.*

If I am authorizing the release of HIV related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

_____

Patient/Authorized Representative Signature Printed Name Date

Relationship to Patient: _____

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Complete form, save on your computer or device, then create an email and send back to one of the clinics below:
Medical: medical@grandpeaks.org Dental: dental@grandpeaks.org Behavioral Health: behavioralhealth@grandpeaks.org