

This message is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this facsimile in error, please notify sender immediately by telephone and return to the address below. We will reimburse your telephone and postage expense for doing so. If you are the recipient of patient information it is prohibited from disclosing the information to any other party and is required to destroy the information after the stated need has been fulfilled. Thank you.

BOUNDARY COMMUNITY HOSPITAL
6640 Kaniksu Street
Bonnors Ferry, ID 83805
Telephone: (208) 267-3141 Fax: (208) 267-6352

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
FROM BOUNDARY COMMUNITY HOSPITAL

IDENTIFYING DATA

Patient's Name: _____ Medical Record No. _____
Address: _____
Date of Birth: _____ Telephone: _____ Other identifying information: _____

AUTHORIZATION

I hereby authorize Boundary Community Hospital, 6640 Kaniksu Street, Bonnors Ferry, Idaho 83805-9500 to release medical information as described below to:

(Name)

(Street Address) (City, State, Zip Code)

* This form is not used to release information for treatment or payment from BCH.

INFORMATION TO BE RELEASED

Under Federal Substance Abuse Confidentiality Requirement, an authorization must include the purpose of the disclosure of substance abuse information even if the patient requests the disclosure. The recipient of the information is prohibited from disclosure.

Please check the appropriate box below or describe your request in full under "Other"

- | | |
|---|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Treatment for Substance Abuse - <input type="checkbox"/> Drugs <input type="checkbox"/> Alcohol |
| | Purpose _____ |
| <input type="checkbox"/> Medical History and Physical Examination | <input type="checkbox"/> Treatment for Mental Conditions |
| | Purpose _____ |
| <input type="checkbox"/> Outpatient Clinical Notes | <input type="checkbox"/> Test Results (Specify) |
| <input type="checkbox"/> Other: _____ | |
| | (Describe in Full) |

I understand that person or entity that receives the information is not a health care provider or health care plan covered by privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

DURATION OF AUTHORIZATION

This authorization shall become effective immediately and shall remain in effect, unless revoked in writing, for a period of:

- 3 months Other (specify): _____

USE OF INFORMATION AND RESTRICTIONS

The recipient may use the information furnished solely for the purpose indicated below. Furthermore, the recipient may not further use or disclose that information unless another written authorization is obtained (except where specifically required or permitted by law).

- | | |
|---|---|
| <input type="checkbox"/> Medical Care | <input type="checkbox"/> Insurance billing verification |
| <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Insurance policy application |
| <input type="checkbox"/> Other (specify) _____ | |

YOU MAY RETAIN A COPY OF THIS AUTHORIZATION Initial here to indicate you received/retained your copy: _____

AUTHORIZING SIGNATURE

(Signature of Patient or Responsible Party)

(Date)

(Witness)

(Relationship of Responsible Party to Patient)

(Date)