North Canyon
MEDICAL CENTER

Date Received: _____
Sent to HIM: Yes ☐ No ☐
Dept. HIM ☐ Other ☐ _____
Processed by: _____ Date: _____
Faxed: ☐ Mailed: ☐ Picked up: ☐ Emailed: ☐
ID Verified: _____ (Initial)

Authorization to Obtain/Release Medical Records

PATIENT NAME: _____ DOB:_____

ADDRESS: _____ PHONE:_____

THIS IS TO AUTHORIZE THE DESCRIBED MEDICAL RECORDS REGARDING THE ABOVE PATIENT TO BE RELEASED TO____ OR FROM____:

NORTH CANYON MEDICAL CENTER
MEDICAL RECORDS DEPARTMENT
267 N CANYON DRIVE
GOODING, ID 83330
OFFICE: (208) 934-4433
FAX: (208) 934-8643 OR (208) 735-3732
EMAIL: ROI@NORTHCANYON.ORG

RECORDS TO BE RELEASED FROM____ TO____:

FACILITY/PROVIDER/INDIVIDUAL:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

PHONE #:_____FAX #:_____

RECORDS REQUESTED (check all that apply): **Date: From _____ To _____**

_____ **ALL RECORDS**	_____**EMERGENCY CARE**	_____**QUICK CARE NOTES**
_____ **CONSULTATIONS**	_____**HISTORY & PHYSICAL**	_____**DISCHARGE SUMMARY**
_____ **LAB REPORTS**	_____**RADIOLOGY**	_____**OTHER:** _____

THE FOLLOWING TYPES OF RECORDS REQUIRE SPECIFIC AUTHORIZATION: Each type must **be initialed** below for the request to be valid.

_____PSYCHIATRIC NOTES _____ DRUG ADDICTION TREATMENT _____HIV TREATMENT

THIS AUTHORIZATION IS **VALID FOR 90 DAYS** FROM THE DATE SIGNED UNLESS A DIFFERENT DATE OR EVENT IS SPECIFIED HERE _____.

THIS AUTHORIZATION MAY BE REVOKED AT ANYTIME IN WRITING. TO REVOKE, THE PATIENT MUST SUBMIT A LETTER ASKING THAT IT BE REVOKED TO THE DIRECTOR OF HEALTH INFORMATION. RELEASING YOUR MEDICAL INFORMATION AS A RESULT OF THIS AUTHORIZATION MAY MEAN THAT YOUR MEDICAL INFORMATION COULD BE RERELEASED BY THE RECIPIENT AND NO LONGER BE PROTECTED BY FEDERAL PRIVACY RULES.

PATIENT SIGNATURE: _____ DATE: _____