IDAHO SPORTS MEDICINE INSTITUTE™

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AUTHORIZATION TO DISCLOSE OR REQUEST MEDICAL INFORMATION

Patient's Name (Printed): _____ **Date of Birth**: _____

Previous name (if applicable): _____ **Phone**: _____

_____

Address City State Zip Code

Request Records From:

Name/Organization: _____

Address: _____

_____

City State Zip

Phone: _____ Fax: _____

Release Records To:

Name/Organization: _____

Address: _____

_____

City State Zip

Phone: _____ Fax: _____

Preferred Method: ☐ Fax ☐ Email ☐ Mail ☐ Pick up @ ISMI when ready

Secure email services are available only with the use of an encryption service or through the ISMI patient portal which require an account setup and password to access records.

Email: _____

Information Requested:

☐ Chart Notes ☐ History & Physical ☐ Rehabilitation Notes
☐ X-Ray (Film) ☐ Operative Report ☐ Billing Statement
☐ MRI Report ☐ Lab/Path ☐ Video Eval/T.Drive
☐ Other_____

Dates of Treatment Requested: _____

Records Relating to Right/Left (Knee, Shoulder, Etc.): _____

Select Purpose For Use Of Medical Records:

☐ My personal records ☐ Sharing with other health care providers ☐ Other _____

This release will expire on: _____/_____/_____ Or no later than 90 days from date of signature.

DO NOT SIGN BEFORE READING BELOW

The person and/or institution providing this information is hereby released from all legal responsibility or liability for the release of the information provided above. I understand that I have the right to withdraw this authorization at any time and that such revocation must be in writing. Further, I understand that this authorization, without prior revocation, will expire 90 days from the date of signature. ***Please allow ISMI 8-10 business days to process your request.***

SIGNATURE:_____Date:_____

(Patient or person giving consent if minor or not the patient)

If other than patient, indicate the relationship and the reason for signing: _____

NOTICE: Please be advised that release of information authorized by this document may result in the waiver by the patient of certain legal rights, including the protection of the physician/patient privilege and rights under the federal alcohol and drug abuse acts and Idaho laws relating to involuntary commitment, mental illness or privacy about tests or treatment of sexually transmitted disease and/or HIV/AIDS. If you have any question about waiving these rights, you are advised to consult your attorney.

Office Use Only

_____ _____

Date Completed By (Print Name) ☐ Email ☐ Mailed ☐ Faxed ☐ Patient Picked Up

Revised 4/6/18 DP