AUTHORIZATION OF DISCLOSURE OF PROTECTED HEALTH INFORMATION (RELEASE OF MEDICAL INFORMATION)

Tripp Family Medicine, Inc.

1411 Fillmore Street, Suite 600, Twin Falls, ID 83301 Phone: 208-933-4400 Fax: 208-933-4401

Patient: ____ DOB: __________________

❍ **REQUEST FOR RECORDS** I authorize: ____*

to disclose/forward protected health information ____

to Tripp Family Medicine, Inc. Phone: ______________ FAX: ________________

**Please provide within 14 days per Federal regulations.*

❍ **RELEASE OF RECORDS** I authorize Tripp Family Medicine, Inc.

to disclose/forward protected health information to: ____

❍ Paper copy (fee associated __________) ____

❍ Digital Copy (USB drive, Email, CD, Portal, etc.) Phone: ______________ FAX: ________________

Information requested to be disclosed/ forwarded (choose one):

- All of my health information, including any medical history, mental or physical condition and any treatment received by me.
- Past 12 months of all screenings and diagnostic results.
- All of my health information described above except for the following: ____________________ ____
- Only the following records or types of health information:
  - Imaging _____________ ____________________
  - Other: ______ ____________________ _____________

I understand that:

- Information used or disclosed due to this authorization may be rendered to the above named person(s) and/or entities and may no longer be protected by federal or state law
- I do not have to sign this release in order to receive treatment.
- I have the right to inspect or copy the information disclosed.
- This authorization shall be in effect until revoked in writing by me, my written revocation must be submitted to Tripp Family Medicine.

Signature:____ Date:________________________

Print Name:____ Relationship:__________________

Witness:____ Date Released: _________________