BOISE KIDNEY
& HYPERTENSION INSTITUTE

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# AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

Patient Name:_____ Date of Birth:_____
(Please Print Clearly)

Phone:_____ MRN: _____

I Authorize: Boise Kidney and Hypertension Institute *(please check one)*

____ to **RECEIVE** records **FROM:**

____ to **SEND** records **TO:**

_____
Name/ Facility Address

_____
Phone Fax

For the following purpose: _____

Information to be released:

___ ALL MEDICAL RECORDS (OR)

___ Chart Notes ___ Medication List ___ List of Allergies

___ Immunization record ___ Imaging results ___ Lab results

___Other (Please specify)_____

I understand that the information in my health record may include information relating to STDs, AIDS or HIV. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand that I have the right to revoke this authorization at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations. This consent will expire 1 year from the date signed unless revoked earlier.

Patient Signature:_____ Date:_____
(or Legal Representative)

Witness Signature:_____ Expiration Date:_____