Bear Lake Memorial Hospital

Count on Us to Care

Montpelier, Id 208-847-1630 www.BLMHospital.com

"The Most Caring Hospital on Earth"

Authorization for Inspection, Use and Disclosure of Protected Health Information

MR # _____

Print Name: _____ Date of Birth: _____

Address: _____

Last 4 Digits of Social Security #: _____. Telephone: ( ) _____

1. Information To Be Release-Covering the following periods of Health Care:

Month/ Year _____ Month/Year _____

Month/ Year _____ Month/Year _____

☐ Complete Health Record	☐ OP Reports	☐ X-Ray films/images
☐ Complete Health Record-Inspection Only	☐ Discharge Summary	☐ Laboratory Test Results
☐ History and Physical	☐ Progress Notes	☐ Photograph, Videotapes, digital/other images
☐ Consultation Reports	☐ X-Ray Reports	☐ Complete Health Record

☐ Other (Specify) _____

2. Purpose of Request

☐ Treatment or Consultation	☐ At the request of the Patient	☐ Billing or claims payment

☐ Other (Specify) _____

3. Person Authorized to Receive Information

Name: _____

Address: _____

4. Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS/Genetic Testing Records Release

I understand that if my medical record contains information in reference to drug and/or alcohol abuse, psychiatric care, communicable disease and Genetics Testing, I agree to its release. **Initials**_____.

IF NO: ☐CHECK BOX, INITIAL HERE AND SPECIFY_____.

5. Time Limit & Right to Revoke Authorization

Unless revoked, this authorization will be valid until the information is release. To revoke my authorization, I must Submit in writing my request in writing to Bear Lake Memorial Hospital, HIM/Medical Records Department, 164 South Fifth Street Montpelier, ID 83254

6. Re-disclosure/Treatment

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers, and physicians are herby released from any legal responsibility or liability for disclosure or the above information. I understand that Bear Lake Memorial Hospital will not condition treatment on my signing this authorization. Bear Lake Memorial Hospital will not deny me treatment if I do not wish to sign this form. I may refuse to sign this authorization form.

Signature: _____ **Date:** _____

Authority to Sign if not patient: _____

7. Identity of Requestor Verified via: ☐ Photo Id ☐ Matching Signature ☐ Personally Known ☐ Other Specify_____.

Verified by: _____