412 S. King Ave. Ste 100 Middleton, ID 83644 Ph. 1.208.585.2568 Fx. 208.585.2574

Authorization for Use and/or Disclosure of Protected Health of Information

Patient Name: (Print)	Date of Birth:
Patient Address	

I, or my legally authorized representative, request that protected health information regarding my care and treatment be released as described below :

In conjunction w ith Idaho State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), HITECH, and the Final Omnibus Rule, I understand the follow ing:

A. This authorization may include the disclosure of personal information relating to Alcohol, Drug Abuse, and Mental Health. HIV/AIDS information, as w ell as psychotherapy notes w ill also be included if I initial here _______

B. If the above has been initialed, I have authorized the disclosure of this sensitive personal health information to the provider, entity, or legal personal representative listed below . The recipient of this information is prohibited from redisclosing such information w ithout my prior authorization unless authorized to do so under state or federal by law .

C. I also understand that I have the right to refuse to sign this authorization, that it is voluntary, and w ill not affect my treatment or payment of health care.

D. I understand that I may revoke this authorization at any time, to the extent that action has not already been taken that w as based on this authorization. If I choose to to exercise my right to revoke this authorization, I w ill do so in w riting to AAA Medical Solutions, Inc. to the address listed in section H below .

E. If the receiving party is not subject to the Privacy Rule, the information may be redisclosed by the recipient and may no longer be protected by federal or state law .

F. A copy of this signed authorization w ill be provided to me for my records.

G. This authorization does not allow AAA Medical Solutions, Inc. to discuss or disclose my protected health information w ith anyone other than the providers, entities, or individuals listed below .

H. Name and Address of health care provider releasing information:
AAA Medical Solutions, Inc. 412 S King Ave. Ste 100 Middleton, Idaho 83644

I. Information to be released:

☐ Entire health record
☐ Record from (insert dates)_________to _________
☐ Test Results on date of service (insert date)_______
☐ Signed patient information sheet
☐ Physician's order for date of service __________
☐ Other ________________________________

J. Reason for the release of information:

☐ Personal Use ☐ Continuing Care ☐ Other ________________________________

K. This authorization shall remain in full force and effect until (date)___________
If I decide not to enter an expiration date above, I understand that this authorization will by default be in effect for two years

L. Name(s), address(es) and phone number of the individual(s) or entity(s) to w hom my Protected Health Information may be discussed/disclosed

1	Name: Address:	Phone Number:
2	Name: Address:	Phone Number:
3	Name: Address:	Phone Number:

M. Printed name of person signing this form, if not patient:____

N. Legal authority of person signing for patient:____
If signer is POA or another attorney representing the patient, you must also submit a copy of legal documentation that verifies authority

O. Signature of Patient or Personal Representative:	Date:
____	____