BOUNDARY COMMUNITY HOSPITAL
6640 Kaniksu Street
Bonners Ferry, ID 83805
Telephone: (208) 267-3141 Fax: (208) 267-6352

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM BOUNDARY COMMUNITY HOSPITAL

IDENTIFYING DATA

Patient's Name: _____ Medical Record No. _____
Address: _____
Date of Birth: _____ Telephone: _____ Other identifying information: _____

AUTHORIZATION

I hereby authorize Boundary Community Hospital, 6640 Kaniksu Street, Bonners Ferry, Idaho 83805-9500 to release medical information as described below to:

_____
(Name)

_____
(Street Address) (City, State, Zip Code)

* This form is not used to release information for treatment or payment from BCH.

INFORMATION TO BE RELEASED

Under Federal Substance Abuse Confidentiality Requirement, an authorization must include the purpose of the disclosure of substance abuse information even if the patient requests the disclosure. The recipient of the information is prohibited from disclosure.

Please check the appropriate box below or describe your request in full under "Other"

□ Discharge Summary
□ Medical History and Physical Examination
□ Outpatient Clinical Notes
□ Other: _____ (Describe in Full)
□ Treatment for Substance Abuse - □ Drugs □ Alcohol Purpose _____
□ Treatment for Mental Conditions Purpose _____
□ Test Results (Specify)

I understand that person or entity that receives the information is not a health care provider or health care plan covered by privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

DURATION OF AUTHORIZATION

This authorization shall become effective immediately and shall remain in effect, unless revoked in writing, for a period of:
□ 3 months □ Other (specify): _____

USE OF INFORMATION AND RESTRICTIONS

The recipient may use the information furnished solely for the purpose indicated below. Furthermore, the recipient may not further use or disclose that information unless another written authorization is obtained (except where specifically required or permitted by law).

□ Medical Care
□ Disability Determination
□ Other (specify) _____
□ Insurance billing verification
□ Insurance policy application

YOU MAY RETAIN A COPY OF THIS AUTHORIZATION Initial here to indicate you received/retained your copy: _____

AUTHORIZING SIGNATURE

_____ _____
(Signature of Patient or Responsible Party) (Date)

_____ _____ _____
(Witness) (Relationship of Responsible Party to Patient) (Date)