L I F E S T A G E S
Family Practice OB/GYN
3908 E Flamingo Ave, Nampa, ID 83687
Phone: *(208) 442-8035*
Fax: *(208) 442-8038*

Authorization to Release Medical Record Information

Patient Name____________________________________Birth Date____________________
Address_____________________________CITY________________ZIP_________________
Phone_________________ Social Security#_________________________

I understand that this authorization extends to all or any part of the records/information designated below, which may include treatment for physical and mental illness, alcohol/drug abuse.

To or From: **LIFESTAGES**
(Circle one) **3908 E Flamingo Ave,**
Nampa, ID 83687

To or From: ____
(Circle one) ____
____

To be released:
_____All Medical Records
_____Hospital Records/Operative reports
_____Laboratory Records/X-Ray reports Other________________

This authorization is valid for 6 months unless revoked in writing earlier. If not otherwise revoked, this authorization will expire in 180 days or ________(insert date).

Patient or Guardian______________________________Date____________

Witness Signature_____________________________Date________________

Special Authorization for the RELEASE of Specially-Protected Medical Information
I authorize release of the above-listed recipient the following records concerning the patient designated above.
__________**Drug and/or alcohol abuse records**
__________**HIV test results**

Signature_______________________________Date________________________

Notice to Recipient: Prohibition of Re-Disclosure

"This information has been disclosed to your from records whose confidentiality is protected by Federal Law. Federal regulations (42CFR, Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose."