Family Health Care
1075 N Curtis Rd.
Suite 100
Boise, ID 83706
(208) 377-5166
Fax # (208) 375-0599

David A. Ballance, MD
Jane N. Young, ND, CRNP
& Associates

AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Phone #: _____

This request is to authorize that copies of medical records regarding the above stated patient be released.

FROM: Family Health Care
1075 N Curtis Rd.
Suite 100
Boise, ID 83706

SENT TO: _____
physician

_____
address

_____
city state zip phone fax

Reason for release: ❑ Transfer of care ❑Specialist ❑ Other _____

I hereby authorize and request the release of the following records to the above address.

❑ Lab work ❑ Surgery ❑ Pathology ❑ Radiology ❑ Chart Notes ❑ Other_____

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), or other sexually transmitted diseases, drug and or alcohol abuse, mental illness or psychiatric treatment. I give authorization for these records to be released.

This consent will expire one hundred twenty (120) days after the signed date below. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing I notify Family Health Care in writing to that effect. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

_____ _____
Patient Signature Date

Relationship to patient: _____

There may be a $45 fee for the requested records. Please inquire if this applies to you.
Date Payment Requested_____
Date Payment Received_____