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moscow family medicine
Student Health Clinic

Request for Release of Medical Records
**** PLEASE PRINT ****

Records From:	**Records To:**
_____	UI Student Health – Moscow Family Medicine, PA
MD or Group Name	**MD or Group Name**
_____	831 Ash St
Mailing Address	**Mailing Address**
_____	Moscow, ID 83844-4201
City, State, & Zip Code	**City, State, & Zip Code**

Patient Information:

Name:_____

Other (maiden) name:_____

Birth date:_____ SSN#:_____

Contact Phone Number: _____

I hereby request and authorize the release of requested health care information from the above-named party to the corresponding above-named party. This authorization will expire one year from the date signed below, unless I revoke it earlier. I can revoke it by signing a corresponding revocation of authority. I understand that information I authorize to be released may be subject to re-disclosure by the recipient.
The information that I request to be released is:

- ❒ RECORDS FROM THE PREVIOUS 2 YEARS
- ❒ Progress Notes Only
- ❒ Laboratory Results
- ❒ AIDS/HIV/STD Information
- ❒ All Records
- ❒ History & Physical Exam Notes
- ❒ Imaging Reports
- ❒ **Psychotherapy notes** _____ **Initial**
- ❒ EKG Reports
- ❒ Other_____
- ❒ Other_____
- ❒ Electronic Format

The time period of records I request to be released includes:

❒ ALL DATES ❒ From _____ to _____

PURPOSE OF RELEASE: ❒ Transfer of Care ❒ Personal Use ❒ Insurance ❒ Attorney/Legal request ❒ Other

I authorize the release of information as described above. I understand that there may be a charge for this service, and I agree to pay said charge on demand. This authorization will expire one year from the date signed below, unless I revoke it earlier. I can revoke it by signing a corresponding revocation of authority. I understand that information I authorize to be released may be subject to redisclosure by the recipient.

_____ _____
Patient or Guardian Date

_____
If guardian, relationship

Minor Aged 14-17

If the patient is aged 14 years or older, only the patient may authorize release and/or disclosure of information related to sexually transmitted disease. I understand that my signature below authorizes release of this information. Authorization is valid for 1 year unless revoked earlier, and I can revoke this authorization by signing a corresponding revocation of authority. I understand that information I authorize to be released may be subject to redisclosure by the recipient.

_____ _____
Patient Date