UI Student Health Center
875 Perimeter Dr. MS 4201
Moscow, ID 83844-4201
Telephone: 208-885-6693
Fax: 208-885-5354

moscow family medicine
"Improving the Quality of Your Life"

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

Records From:

_____
MD or Group Name

_____
Mailing Address

_____
City, State, & Zip Code

Phone/Fax #: _____

Records To:

UI Student Health
MD or Group Name

___875 Perimeter Dr MS 4201_____
Mailing Address

___Moscow, ID 83844-4201_____
City, State, & Zip Code

Phone/Fax #:_____

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 and returning to the address below.
The information that I request to be released is:

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

❒ TRANSFER OF CARE (PROVIDERS SEE NOTE) OR ❒ Only dates from _____to _____

❒ Progress Notes Only ❒ EKG Reports Only ❒ Laboratory Results Only ❒ Imaging Reports Only ❒ Immunizations

I understand the information I authorize to be released may include STD's, Mental Health and drug/alcohol and be subject to re-disclosure by the recipient. I understand that there may be a charge for this service, and I agree to pay said charge on demand.

_____ _____
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 re-disclosure by the recipient.

_____ _____
Patient Date

NOTE TO PROVIDERS: For transfer of care, please limit records to patient demographics, current medication list, problem list, last two office visits, most recent lab reports, most recent EKG, recent imaging reports, most current colonoscopy report with pathology report, most recent echo, and any other information your practice feels relevant to this patient's care. Thank you.