Teton Medical Group

255 North 3rd East
Rexburg, Idaho 83440
Phone: 208-356-7585
Fax: 208-356-7566

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____ _____ _____
Print Patient's Name | Date of Birth | Acct. # (internal use)

By signing this authorization, I authorize:
TETON MEDICAL GROUP
255 NORTH 3RD EAST
REXBURG, IDAHO 83440
208-356-7585 FAX: 208-356-7566
Email: tetonmedicalgroup@hotmail.com

To release to:
Name _____
Address _____
City/State _____Zip_____
Phone _____ Fax _____

The following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of service, type of services, level of detail to be released, origin of information, etc.):

- ☐ All Records ☐ Radiology Reports ☐ Laboratory/Pathology Reports
- ☐ Progress Notes ☐ Operative Reports ☐ Financial Records
- ☐ Other_____

Covering the period(s) of care from _____ to_____.
I understand that information relevant to HIV testing and/or AIDS – related diagnosis(es) may be contained in this information. I understand this information may also include reference to psychiatric or treatment for substance abuse.

The information will be used or disclosed for the following purpose: _____
If requested by the patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.
This authorization will expire on _____ not to exceed 24 months.
The information may be faxed if less than 25 pages. Please mail if larger than 25 pages. _____
I understand that I have a right to inspect and copy my own protected health information to be used or disclosed under this authorization. The practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI. I understand and agree to pay a reasonable copying fee to cover the cost of transfer. I also understand that I do not have to sign this authorization in order to receive treatment from *Teton Medical Group.* In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that *Teton Medical Group* has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at the address above.

Signed by: _____ _____
Signature of Patient or Legal Guardian | Relationship to Patient

_____ _____
Print Name Legal Guardian of applicable | Date Signed

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION