Integrative Health Solutions

1215 Michigan St, Suite B
Sandpoint, ID 83864
main: (208) 265-2418
fax: (208) 263-0583
integrativehealthsolutions.org

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

RELEASE INFORMATION **FROM** (Select):

☐ Michael R. DiBenedetto, MD, PLLC
DBA Woodlands Family Medicine
30544 Hwy 200 Ste 101, Ponderay ID 83852

☐ Other: _____
Address: _____
Fax : ( ) _____

RELEASE INFORMATION **TO** (Select):

☐ Integrative Health Solutions, PLLC
1215 Michigan Street Ste B, Sandpoint ID 83864
fax: (208) 263-0583

☐ Other: _____
Address: _____
Fax : ( ) _____

Information authorized do be released:

- ☐ Transfer of Care
- ☐ Last year of Complete Chart Record
- ☐ Medication Record
- ☐ Last Labwork
- ☐ Last Radiology report

Note to Providers Offices: For transfer of care, please limit records to patient demographics, current medication list, problem list, last two office visits, most recent labwork, EKG, PAP, growth charts, mammogram and colonoscopy, and any other information your practice feels relevant to the patient's care.

The purpose for which disclosure is authorized:

☐ Attorney ☐ Provider ☐ Insurance ☐ Personal ☐ Other_____

PATIENT AUTHORIZATION:

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

EXCLUDE the following information from the records released (please initial):

___Drug/Alcohol treatment/diagnosis
___Mental Illness or psychiatric diagnosis/treatment
____Sexually transmitted disease
___HIV/Aids diagnosis/treatment/testing

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used/disclosed by this authorization. There may be a charge for these copies. I understand that I may revoke this authorization at any time by notifying Sandpoint Health Care in writing. This will not have any effect on any actions Sandpoint Health Care took before they received the revocation.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing, and drug/alcohol diagnosis, treatment or referral information.

I understand that this authorization will expire 1 year from the date signed or on __/__/___ (MM/DD/YY) Initial

_____ _____

Signature of Patient or Patient Representative Date