

## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Date of Request: \_\_\_\_\_ Date Needed: \_\_\_\_\_

**\*\* Please note it may take 3-5 business days to complete the release process. \*\***

Release to/receive from (use and disclose) my individually identifiable medical records (Protected Health Information "PHI") in the manner described below. I understand that my PHI may be re-disclosed by the person or entity receiving my PHI from NIEI, and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such re-disclosure by the person or entity receiving my PHI from NIEI. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form.

<input type="checkbox"/> I authorize the North Idaho Eye Institute <b>to release information to:</b>
Name of Provider
Address
City/State/Zip Code
Phone # and/or Fax # <b>Method of Delivery:</b> <input type="checkbox"/> Mail <input type="checkbox"/> Fax <input type="checkbox"/> Pick Up

OR

<input type="checkbox"/> I authorize the North Idaho Eye Institute <b>to obtain information from:</b>
Name of Provider
Address
City/State/Zip Code
Phone # and/or Fax #

**Type or Records Requested: (Check one)**

- Dates of Service: \_\_\_\_\_ - \_\_\_\_\_
- Last exam  Include Tests (Visual Fields, OCT, Photos)
- Other \_\_\_\_\_

**Authorization Valid For: (Check one)**

- This request only  Expires in 1 year: \_\_\_\_\_

**Purpose for this request: (Check one)**

- Transfer of Care     Insurance Coverage     Personal Healthcare     Other

I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying NIEI in writing. I understand that my revocation or modification of this authorization will not affect any actions taken by NIEI in reliance of this authorization before NIEI receives my request for revocation or modification. I must sign my written request and send it to:

**NORTH IDAHO EYE INSTITUTE  
1814 LINCOLN WAY  
COEUR D'ALENE, ID 83814  
ATTN: MEDICAL RECORDS DEPT**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

If not signed by the patient, please indicate relationship: \_\_\_\_\_