NORTH IDAHO EYE INSTITUTE

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.

☐ I authorize the North Idaho Eye Institute **to release information to:**	**OR**	☐ I authorize the North Idaho Eye Institute **to obtain information from:**
Name of Provider		Name of Provider
Address		Address
City/State/Zip Code		City/State/Zip Code
Phone # and/or Fax # **Method of Delivery:** ☐ **Mail** ☐ **Fax** ☐ **Pick Up**		Phone # and/or Fax #

Type or Records Requested: (Check one)

☐ Dates of Service: _____ - _____

☐ Last exam ☐ Include Tests (Visual Fields, OCT, Photos)

☐ Complete Record ☐ Exclude: _____

☐ 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: _____