PH: (208) 375-0722
FAX: (208) 375-0015

2036 N. COLE RD.
BOISE, ID 83704

WWW.NCIDAHO.COM

Request for Release of Confidential Medical Information

Records From:

_____
MD or Group Name

_____
Mailing Address or Fax Number

_____
City, State, & Zip Code

Records To:

_____
MD or Group Name

_____
Mailing Address or Fax Number

_____
City, State, & Zip Code

Patient Information:

Name: _____

Date of Birth: _____

Contact Phone Number: _____

Identification Verified: □ YES Type of ID: _____

Purpose of Release: □ Transfer of Care □ Personal Use □ Insurance □ Legal Request □ Other

Please Send: □ All Records **OR** Date Range: From _____ To _____

I hereby request and authorize the release of requested medical 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 understand the information I authorize to be released may include STD's, Mental Health and Substance Abuse and be subject to re-disclosure by the recipient.

_____ _____
Patient or Guardian Date

_____
If Guardian, Relationship