1560 North Crestmont Drive, Suite A
Meridian, Idaho 83642
P: 1-208-650-4888
F: 1-208-650-4892

Authorization to Receive Medical Records/Information

I authorize the release of my medical records by the organization or provider listed below:

Provider Name: _____

Provider Address: _____

Provider Phone #: _____Fax # of Provider: _____

These records are to be sent to Tarter Family Medicine at the address listed above.

Patients Name: _____ Date of Birth_____

Address: _____State: _____ Zip Code: _____

Social Security #: _____Phone #: _____

The type and amount of information to be disclosed is initialed as follows:

_____X-ray films
_____Immunizations
_____Most recent 3 years of records
_____Entire Medical Record
_____Substance and Drug Abuse, if any
_____AIDS/HIV, if any
_____Genetic testing
_____Psychological or psychiatric conditions

Other: _____

I understand this authorization will expire, without my revocation, one year from the date of signing, or if I am a minor, on the date I become and adult according to the state law. I understand that I may revoke this authorization in writing at any tie except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company. I understand that any disclosure or information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I accept full financial responsibility for any copying or shipping fees and any applicable sales tax that may be charged.

_____ _____
Patient's Name Date

_____ _____
Signature Patient /Patient's Parent/Guardian/Representative Relationship to Patient