CASCADE MEDICAL CENTER

CASCADE FAMILY PRACTICE
P.O. Box 1330
Cascade, ID 83611
Phone: 208 382-4285 Fax: 208 382 -5081

Release Records To: Cascade Family Practice

Release Records From: _____

Address: _____

Regarding the Following Patient:
Patient Name _____ Phone # _____

Other Names _____ Date of Birth_____

Address _____ SSN # _____

Records to be Released:
Date(s) treatment was received: _____

__ Consultation Report __ History and Physical __ Laboratory Report
__ Operative Report __ Pathology Report __ Progress Notes
__ X-Ray Film __ X-Ray Report __ Photographs, Videos, Digital or Other Images
__ Entire Record __ Certified Copy __ Other _____

I authorize the release of information relating to: __ HIV/AIDS Testing/Treatment
__ Psychiatric Evaluation/Treatment __ Alcohol/Drug Abuse Evaluation/Treatment

Purpose of Release:
__ Continuing Care __ Insurance __Litigation __ Personal Use __ Other _____

This authorization expires on the following date, event or condition: _____
If I do not specify any expiration date, event or condition, this authorization will expire in one year.

Statement of Authorization:
Except to the extent that action has already been taken, I understand that I may revoke this authorization at any time by giving written notification to Health Information Services (Medical Records). A photocopy/fax of this authorization will be treated in the same manner as the original.

I do not authorize further release to any third party without my written consent. I understand that once information is released as specified in this authorization, the facility, their employees and my physician(s) cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.

_____
Signature of Patient/Legally Authorized Representative Date

_____
Relationship to Patient Reason Patient Unable to Sign

_____
Signature of Witness (Verbal Authorization Only) Signature of Witness (Verbal Authorization Only)

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FOR OFFICE USE ONLY

Medical Records Released By: _____ Date: _____ MR#: _____

__ Copies __ Review

AUTHORIZATION FOR RELEASE OF INFORMATION