Frontier Pediatric Partners
1502 Locust Street N, Suite 700
Twin Falls, ID 83301
Phone 208-595-5095 Fax 208-595-5258

Authorization for Release of Patient Identifiable Health Information

Patient Name_____ DOB _____
Phone# _____ Current Address: _____

1. I authorize the use or disclosure of the above named individual's health Information as described below.

2. Name of person or agency information released **TO**: Frontier Pediatric Partners
Address: 1502 Locust St N, Ste 700 City: Twin Falls State: ID Zip: 83301
Phone: 208-595-5095 Fax: 208-595-5258

Name of Person or agency information released **FROM**: _____
Address: _____ City:_____ State:___ Zip:_____
Phone: _____ Fax: _____

3. Purpose of need for information: _____

4. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)
From (date) _____To (date) _____

___ Immunization Record ___ Growth Chart ___ Office Notes ___ Laboratory Reports

___ Radiology Reports ___ ER Reports ___ Hospital Records ___ Psychological Eval

___ Consultation Reports From (Dr's Names):_____

___ Other (Specify): _____

5. I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Practice Manager. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company and as law proves my insurer with the right to contest a claim under my policy. This authorization will expire in 180 days unless otherwise specified. Unless otherwise revoked, the authorization revoked, the authorization will expire on the following dates, event or condition:_____
_____

Signature of Patient / Parent_____ Date _____

If signer is not the patient:

Print Your Name _____ Relationship to Patient _____