Franklin County Medical Center , Transitional Care &
Willow Valley Clinic

44 North 1st East
Preston, Idaho 83263
(208)852-0137
(208)852-3590 FAX

Patient Name:_____
Birth Date:_____
Address:_____
Phone Number: _____
Medical Record Number:_____
☐ Pick up copies ☐ Fax Copies
☐ Mail copies ☐ View Record
ID Confirmed by: _____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Franklin County Medical Center & Willow Valley to disclose health information as specified:

To: _____
Name of organization/Person to receive the health information

_____
Street Address

_____
City State Zip Code

Information to be disclosed: Date(s) of Hospitalization/Care:_____

- ☐ Discharge Summary
- ☐ History & Physical Exam
- ☐ Consultation Reports
- ☐ Operative Reports
- ☐ Lab
- ☐ Pathology
- ☐ Radiology Reports
- ☐ Entire record
- ☐ Other specify: _____

I understand that the disclosure may include information relating to (check if applicable):

- ☐ AIDS or HIV
- ☐ Psychiatric or Mental Health Information
- ☐ Drug/Alcohol Abuse information

I understand that the information to be released may include material that is protected by Federal Law (45CFR Part 164) and that the information may be subject to redisclosure by the recipient and no longer be protected by the federal regulations. I understand that this authorization may be revoked in writing at any time by notifying the privacy officer, except that revoking the authorization won't apply to information already released in response to this authorization. I understand that FCMC will not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. **Unless otherwise revoked, this authorization will expire in 90 days from the date below or in the event of the following condition**:_____

Franklin County Medical Center, its employees, officers, and physicians are hereby released from any legal responsibility or liability of disclosure of the above information to the extent indicated and authorized by me on this form and as outlined in the Notice of Privacy. My signature below authorized release of all information specified in this authorization. Any questions that I have regarding disclosure may be directed to the privacy health officer at 208-852-0137.

_____
Signature of Patient Date

_____
Signature of Legal Representative & Relationship to Patient/Authority to Act Date

_____
Signature of Witness Title Date