



# Sandpoint Women's Health

420 N. 2nd Avenue, #200 • Sandpoint, Idaho 83864  
Phone (208) 263-2173 • Fax (208) 263-7441

## Authorization for Release of Information

The HIPAA Privacy Law allows Sandpoint Women's Health to charge for copies of records. See reverse for details.

**PRINT Patient Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_

I hereby authorize:  \_\_\_\_\_ to release my individually identifiable health information to Sandpoint Women's Health; **or**  Sandpoint Women's Health to release my individually identifiable health information to \_\_\_\_\_.

**Method of receipt/transmission (check one and complete):**

Mail - Address \_\_\_\_\_  Fax - # \_\_\_\_\_  Patient Pick Up

**Purpose for which information is to be used (check all that apply):**

Treatment  Insurance  Personal  Follow Up  Legal  Other: \_\_\_\_\_

**Specific description of information (including dates):**

Core chart (up to 10 pages) – Notes from 3 most recent dates of service, last prenatal record (if applicable), most recent test results

Other \_\_\_\_\_

Please note: If you are requesting anything more than the **Core Chart**, a charge will be incurred (see reverse).

**By initialing below, I specifically authorize the release of information relating to the diagnosis/treatment of :**

Substance Abuse  Psychiatric/mental health  HIV/AIDS/Sexually transmitted disease(s)

I hereby release the providing person(s)/organization(s) from all legal liability that might arise from the release of this sensitive information protected by Title 42 of the Code of Federal Regulations. INITIALS: \_\_\_\_\_

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I consider a copy of this authorization to be as valid as the original. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand that I may see and obtain a copy of the information described on this form if I ask for it and that I may get a copy of this form after I sign it. I understand that a fee for copies may be imposed by the person(s)/organization(s) listed above or by its designated business associate.

I understand that this authorization will expire on \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YY). I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it, by notifying the person(s)/organization(s) listed above.

\_\_\_\_\_  
Signature of Patient or Patient Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Patient Representative

**Prohibition of Redisclosure:** This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR 164.508) prohibit you from making further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for release of medical or other information if held by another party is NOT sufficient for this purpose.  
Rev: 09/20/2010

## Fees for Medical Records

**CORE CHART (up to 10 pages) for personal use:**

- Three most recent dates of service;
- Last prenatal record (if applicable);
- Most recent blood work, pap smear, biopsy, etc.

**Provided at no charge.**

The above documents are typically considered sufficient for continuity of care. If you would like your entire record released, you will be charged for these services (see below). Pre-payment may be required prior to fulfilling your request.

**Requests of more than 10 pages for personal use:**

- 30 pages or less:       \$ 0.50 per page
- 31+ pages:               \$ 0.25 per page
- Additional cost for postage applies

**Requests for records going to a 3<sup>rd</sup> party, attorney, or insurance company:**

- \$25.00 clerical fee
- 30 pages or less:       \$ 0.50 per page
- 31+ pages:               \$ 0.25 per page
- Additional cost for postage applies

**Requests are generally filled within two (2) weeks. If your need is more urgent than our customary timeline, an additional \$10.00 processing fee will be incurred.**

Please note: This notice applies to request for medical records for the clinic only. If you require medical records from the hospital, please contact the hospital medical records department directly.

For Office Use Only

- |   |                           |               |
|---|---------------------------|---------------|
| 1. Core chart for personal use (less than 10 pages)     |                           | No charge     |
| 2. More than 10 pages for personal use                  | # of pages over 10: _____ | Fee: \$ _____ |
| 3. Records for a 3 <sup>rd</sup> party (Addl. \$25 fee) | # of pages: _____         | Fee: \$ _____ |
| 4. Urgent request (less than 2 weeks)                   |                           | Fee: \$10.00  |

Total fee: \_\_\_\_\_

Paid: Y / N    Request fulfilled: Y / N    Initials: \_\_\_\_\_