BONNER GENERAL HEALTH
Sandpoint Women's Health

423 N 3rd Ave, Suite 210 • Sandpoint, Idaho 83864
Phone (208) 263-2173 • Fax (208) 263-7441

Authorization for Release of Information

The HIPPA 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 individual identifiable health information to Sandpoint Women's Health **OR**
- ☐ Sandpoint Women's Health to release my individual 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 (circle 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**. INITIAL**: _____

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 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 one year from the date of my signature. 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.

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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 release, you will be charged for these services (see below). Pre-payment may be required prior to fulfilling your request.

Request of more than 10 pages for personal use:

- 30 pages or less: $0.10 per page
- 31 + pages: $0.05 per page
- Additional cost for postage applies

Request for records going to a 3rd 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 that 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 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 3rd party (Addl $25.00 fee) # of pages:_____ Fee: $_____
4. Urgent request (less than 2 weeks) Fee: $ 10.00

Total Fee: _____

Paid: Y / N request fulfilled: Y / N Initials:_____