**Idaho Falls Arthritis Clinic**
2220 East 25th Street
Idaho Falls, ID 83404
Phone: (208) 542-9080
Fax: (208) 542-9081

Craig D. Scoville, MD, PhD

## Authorization for Disclosure of Patient Information:

Patient's Name: _____DOB_____ Patient's SS Number: _____

Patient's Phone Number's: Home: _____ Cell: _____

Patient's Mailing Address:

_____

_____

**Date Requested: _____ Date Needed: _____**

**I authorize Idaho falls Arthritis clinic to RELEASE Information to:**

Name of Provider/ Patient: _____

Address: _____

Phone Number: _____ Fax Number: _____

**OR**

**I authorize Idaho falls Arthritis clinic to OBTAIN Information From:**

Name of Provider: _____

Address: _____

Phone Number: _____ Fax Number: _____

**Purpose of this request** (Choose one): ☐Health Care ☐Insurance coverage ☐ Personal
☐Transition of Care ☐Other (Specify): _____

**Type of Records Requested** (Choose one) ☐ All Medical Records ☐ Most Recent (1 Year)
☐ Only Labs ☐ Other (Specify): _____

**Authorization Valid For** (check one) ☐ This request only ☐ One year from this request
☐ Other (Specify): _____

**I understand that:**

- My right to healthcare treatment is not conditioned on this authorization
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There could be a Cost for releasing your medical records.

Signature of Patient or Representative: _____ Date: _____