IDAHO FALLS
ARTHRITIS CLINIC
an Affiliate of Mountain View Hospital

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I understand that, under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my "Protected Health Information (PHI)", under a federal health privacy law. I understand that any information obtain by the requesting clinic may and will be used to conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

I hereby authorize the use and disclosure of my Personal Health Information (PHI) as indicated or described below:

- ○ All health information relating to me
- ○ Only the following specific information:

_____

_____

Disclosure may be made to: IDAHO FALLS ARTHRITIS CLINIC
2220 East 25th Street
Idaho Falls, ID 83404
Phone: (208) 542-9080
Fax: (208) 542-9081

I give Idaho Falls Arthritis Clinic authorization to disclose my personal appointment and medical information to the individuals list below (family members, spouse, etc.). I understand if their names are not listed here, no information will be shared without a signed consent from me.

Name: _____ Relationship: _____
Name: _____ Relationship: _____

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____