ADVANCED FAMILY MEDICINE

Authorization for Release of Confidential Medical Information

Printed Patient Name:_____DOB:_____
Street Address:_____
City:_____ State:_____ Zip Code:_____
SS#:_____ Patient's Phone #:_____

Records To Be Released TO / FROM:
(Circle One)

Advanced Family Medicine
943 N Linder Road Suite 103
Kuna, ID 83634
Michael W. Foutz, MD ♦ Molly Armijo, MD
♦ Jordan Finnegan, PA-C
Phone: 208-922-3355 Fax: 678-553-1263

Records To Be Released TO / FROM:
(Circle One)

Facility or Doctor:_____
Address:_____
City:_____
State:_____Zip Code:_____
Phone: (____)_____
Fax: (____)_____

Purpose of Disclosure: _____

Records to be Released:

- ☐ Complete Record
- ☐ Laboratory Results
- ☐ X-Ray Results
- ☐ Clinic Notes
- ☐ Immunization Records
- ☐ Substance Abuse
- ☐ HIV/STD Test Results
- ☐ Mental Health Treatment
- ☐ Other (Please Specify) _____

I acknowledge that data to be released may include material that is protected by Federal Law. I acknowledge the information to be released may include mental or behavioral health records, subtance abuse information or treatment, STD or HIV testing results, and/or genetic testing results. I further acknowledge that thisrelease will be applicable to any of the specific authorizations selected above. My signature below authorizes release of all such information except as otherwise specified. I release AFM staff and counsel from all legal responsibility or liability that may arise from authorized release of information. I understand that this authorization is voluntary and I may refuse to sign. If I refuse to sign this will not affect my right to health care treatment.

Authorization valid for one year unless revoked in writing at an earlier date. I acknowledge that I have the right to revoke this authorization so long as I provide a written statement of my revocation.There may be a charge for requested records. If you are requesting medical records from the past two years there will be no charge for the copying and processing of these records. If you require medical records older than the last 24 months, there may be a fee imposed using the following scale: $45.00 for pages 1-15, $0.25 per page thereafter.

Signature of patient:_____ Date:_____

Guardian printed name: _____ Relationship to patient: _____
(If Patient is under 18 years of age)
Signature of Guardian: _____ Date:_____

Witness printed name: _____

Signature of witness:_____ Date:_____