Authorization to Release Confidential Medical Information

Patient Name (Please Print) ______________________________________Date of Birth____/____/_____

Address____City______________State/Zip__________

I hereby request that a copy or summary of your records INCLUDING LABORATORY & X-RAY reports that you have which contain information relevant to my present and future diagnosis and/or treatment be released.

Records Coming From:

Name: ____

Address: ____

City, State, Zip: ____

Phone #: ______________________ Fax #: ____

Please Fax Records To:
Eagle Health and Wellness
868 E. Riverside Dr.
Suite 200
Eagle, Idaho 83616
Fax # 1-208-209-6058
Phone # 208-938-4040

SPECIFIC AUTHORIZATION

____ Substance Abuse ____ Sexually Transmitted Diseases (STD's)

____ HIV Test Results ____ Mental Health Treatment Information ____ Labs only

I acknowledge that data to be released may include material that is protected by Federal Law and that is applicable to ANY or All of the above. My signature below authorizes release of all such information except as otherwise specified.

Authorization valid for one year unless revoked in writing earlier.

____ ____________________________

Signature *Date*