Idaho State UNIVERSITY

ISU Speech and Hearing
650 Memorial Dr., Bldg. 68, Pocatello, ID 83209
Phone: 208.282-3495 / 208.282.4571

Patient Authorization to Release Protected Health Information (PHI)

Patient Name: _____ **DOB:** _____

Address: _____ **Phone No.:** _____

_____

I authorize ISU's Speech and Hearing Clinic and any of their affiliated entities, employees, agents, or associated health care practitioners to use or disclose the patient's protected health information (PHI) as described below:

1. I authorize the use and disclosure of my PHI to be RELEASED to the following entity:

   Name: _____

   Address: _____

   _____

   Phone: _____ **Fax:** _____

   ☐ Records from: _____ to: _____

   Records to be released: Other: _____

   ☐ Evaluation Reports ☐ X-Ray Reports ☐ Laboratory Tests / Reports
   ☐ Progress Notes ☐ X-Ray Films ☐ Consultation Reports
   ☐ Discharge Summary ☐ Pathology Reports ☐ History and Physical Exam

2. I authorize the use and disclosure of my PHI to be OBTAINED from the following entity:

   Name: _____

   Address: _____

   _____

   Phone: _____ **Fax:** _____

   ☐ Records from: _____ to: _____

   Records to be released: Other: _____

   ☐ Evaluation Reports ☐ X-Ray Reports ☐ Laboratory Tests / Reports
   ☐ Progress Notes ☐ X-Ray Films ☐ Consultation Reports
   ☐ Discharge Summary ☐ Pathology Reports ☐ History and Physical Exam

   If the information includes records or information from another health care provider or entity, that information: ☐ SHOULD or ☐ SHOULD NOT be released under this Authorization. This Authorization applies only to the information indicated above. Additional information shall require another Authorization.

3. The disclosure is for the following purpose (*check one and complete as needed*).

   ☐ Patient Request ☐ Continuity of Care ☐ Legal ☐ Other: _____

I acknowledge that the information to be released MAY INCLUDE information protected by federal and state laws.

The ISU Speech and Hearing Clinic will send information ONLY to the above address or fax number. Any disclosure of the patient's PHI to another person or entity will require another authorization.

This Authorization is valid for one (1) year from the date set forth below. It may be revoked at any time in writing to ISU's Privacy Officer below prior to the expiration of such 90-day period. Revocation of this authorization shall not affect releases to the revocation.

ISU Privacy Officer: James Francel, HIPAA & Privacy Officer
921 S. 8th Avenue, Stop 8410
Pocatello, ID 83209
(208) 282-3022
Email: franjam5@isu.edu

I may refuse to sign this authorization, which will not affect my treatment or payment for health care at the ISU Speech and Hearing Clinic.

After your PHI (medical records) are released by your authorization, the possibility exists that your PHI will no longer be subject to the protection of federal privacy regulations and may be re-disclosed by the recipient.

I certify that I have the authority to approve the requested release of information and sign this authorization.

_____
Patient or Personal Representative Signature

_____
Printed Name

_____
Date of Request