

## Patient Authorization to Release Protected Health Information (PHI)

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Phone No.:** \_\_\_\_\_  
\_\_\_\_\_

I authorize ISU's Bengal Laboratory 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: \_\_\_\_\_

Pathology Reports  Laboratory Tests / Reports

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: \_\_\_\_\_

Pathology Reports  Laboratory Tests / Reports

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 Bengal Laboratory 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. 8<sup>th</sup> 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 Bengal Laboratory.

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