Family Health Care
1075 N Curtis Rd.
Suite 100
Boise, ID 83706
(208) 377-5166
Fax # (208) 375-0599

David A. Ballance, MD
Jane N. Young, ND, CRNP
& Associates

AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL RECORDS

Patient Name: ____________________________________ Date of Birth: ________________

Phone #: ________________________

This request is to authorize that copies of medical records regarding the above stated patient be released.

FROM: ____
physician
____
address
____
city state zip phone fax

SENT TO: Family Health Care
1075 N Curtis Rd.
Suite 100
Boise, ID 83706

I hereby authorize and request the release of the following information to above address.

- ❑ Lab work
- ❑ Surgery
- ❑ Pathology
- ❑ Radiology
- ❑ All Records
- ❑ Other______________________

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), or other sexually transmitted diseases, drug and or alcohol abuse, mental illness or psychiatric treatment. I give authorization for these records to be released.

This consent will expire one hundred twenty (120) days after the signed date below. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing I notify Family Health Care, in writing to that effect. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

____________________________________ __________________
Signature Date

Relationship to patient: ___________________________

PLEASE USE THIS REQUEST AS YOUR FAX COVER SHEET WHEN RETURNING RECORDS. THANK YOU!