

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Idaho Medical Massage

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

1. PATIENT IDENTIFICATION

Patient Name: _____

Date of Birth: _____ Phone Number: _____

2. AUTHORIZATION

I hereby authorize _____ to release my medical records to Amber Koopin, LMT/**Idaho Medical Massage**.

3. INFORMATION TO BE DISCLOSED

All medical records

Progress notes / Treatment plans

Diagnostic imaging reports (X-ray, MRI, etc.)

Other: _____

4. PURPOSE OF DISCLOSURE

Treatment & Coordination of Care

At my request

Insurance Billing

Other: _____

5. EXPIRATION

This authorization will expire:

One year from date of signature

Upon the following date: _____

Upon completion of treatment.

6. PATIENT RIGHTS & DISCLOSURES

- I understand that I may revoke this authorization at any time by notifying the provider in writing.

- I understand that once information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.
- I understand that my treatment, payment, or eligibility for benefits will not be conditioned on signing this authorization.

7. SIGNATURE

Patient/Legal Representative Signature: _____

Date: _____

Idaho Medical Massage is a clinical massage practice focused on pain management and mobility.