

## Release of Information

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_



### Authorization

I authorize **RHS (Rehabilitative Health Services)** to release information to:

I authorize **RHS (Rehabilitative Health Services)** to obtain information from:

Provider/Facility Name: \_\_\_\_\_

Phone (with area code): \_\_\_\_\_

Fax (with area code): \_\_\_\_\_

P: 208-523-5319 F:208-523-5627  
1675 Curlew Dr. Ammon ID 83406

### Requested Records (Check all that apply)

Dates of Service: \_\_\_\_\_

Psychological Testing

Lab Reports

Progress Reviews

Health & Physical

Social/Medical History

Imaging

IEP/504

Comprehensive Diagnostic

Physical Health History

EKG

Probation/Parole Progress

GAIN/ASAM Assessment

Diagnosis

Discharge Summary

Billing

Psychiatric Evaluation

Medication List

Treatment Plans

Other: \_\_\_\_\_

### Reason for Request (Check all that apply)

Continuity of Care

Expansion of Care

Personal

Legal

Changing Services

Other: \_\_\_\_\_

### Privacy Notice / HIPAA

Your health information is protected by federal regulation (Alcohol & Drug Abuse Patient Records, 42 CFR Part 2; and/or HIPAA 45 CFR) and state privacy laws. Disclosure is only permitted with your authorization, except in specific cases outlined in the RHS Privacy Notice.

- For disclosures not related to treatment, payment, or healthcare operations, treatment cannot be conditioned on your signing this authorization (unless care is provided solely to create protected health information for a third-party disclosure).

- You may revoke this authorization at any time, except where action has already been taken based on it.

- This authorization will expire one year from the date signed unless an earlier expiration is requested in writing.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Parent/Guardian Name (if applicable): \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

\*If the client is a minor or adult with a guardian, I acknowledge that I am the parent, legal guardian, authorized representative and have the legal right to make medical decisions, provide informed and voluntary consent on their behalf.\*