Monarch Medical Group

370 North Haven Dr., Ste. 101
Twin Falls, ID 83301
Phone: 732-2200 / Fax: (208) 732-2201

Medical Records Release

Patient Information			
Name (First, Middle, Last):			DOB:
Address:	City:	State:	Zip:
Phone #:	Email:	Medical Record #:	
Other names under which the patient has been treated:			

Records Request Details

Entity Releasing Records			
Entity Name:		Contact Name:	
Address:	City:	State:	Zip:
Phone #:	Fax #:	Email:	
Entity Receiving Records			
Entity Name:		Contact Name:	
Address:	City:	State:	Zip:
Phone #:	Fax #:	Email:	
Information Release Details			
Approximate service date(s):			

Information to be Used or Disclosed:		Purpose of Use and Disclosure:
☐ All Medical Records	☐ Radiology Reports	☐ Insurance
☐ Urgent Care Notes	☐ Film/CD Imaging	☐ Legal
☐ Operative Notes	☐ Clinical Notes	☐ Personal
☐ Discharge Summaries	☐ Nursing Notes	☐ Treatment/Continued Care
☐ Laboratory Reports	☐ History & Physical	☐ Workers Compensation
☐ Patient Billing Records	☐ Providers Orders	☐ School
☐ Emergency Room Notes	☐ Consultations	☐ Occupational Services
☐ Progress Notes	☐ Other:	☐ Employee Wellness
		☐ Other

Choose **one** format for receiving the information:	Delivery Method:	
☐ Paper	☐ US Mail	☐ Overnight/Express
☐ Fax	☐ Pick-up	☐ Certified
☐ Electronic Copy	☐ Fax	☐ Other:
☐ Other: _____	☐ Email	

Patient's Rights

Patient Rights
I understand that: ● The information in my health record may include information relating to acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include behavioral or mental health services and genetic testing information. ● I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance on it. To revoke this authorization, I must submit a written revocation to the releasing facility or practice named above. ● Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in a health plan, or eligibility for benefits. ● My health care cannot be conditioned on this authorization unless the purpose is solely to obtain and disclose information for a third party, such as an employer. ● The information disclosed by Monarch Medical Group's pursuant to this authorization may be re-disclosed by the entity that receives this information and may no longer be protected by privacy regulations. ● I have a right to a copy of this Authorization.

Authorization

Signature of Patient or Patient's Representative	Date
Printed Name	Representative's Relationship to Patient
Witness (optional)	Date

THIS AUTHORIZATION WILL EXPIRE ONE (1) YEAR FROM DATE SIGNED