537 W Bannock St Ste 100 | Boise, ID 83702
Phone: 208-424-7799 | Fax: 208-629-1260 | Chris.Bidiman@alphaidaho.org | alphaidaho.org

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ___________________________________ Date of Birth: ________________________

Previous Name: ___________________________________ Social Security #: _____________________

Allies Linked for the Prevention of HIV & AIDS
537 W Bannock St Ste 100
Boise, ID 83702
Phone: 208-424-7799
Fax: 208-629-1260

Doctor/Organization:_____________________________________

Address:____

Phone:____

Fax:____

I authorize a.l.p.h.a. to: ☐ Release information to the above organization.

I authorize the above organization to: ☐ Release information to Allies Linked for the Prevention of HIV & AIDS

I request the release of the following information (INITIAL ALL THAT APPLY):

______COMPLETE HEALTH RECORD _____Lab Tests/Reports

_____Case Management Notes/Reports _____Other (Specify):___________________________________

The release of information on certain conditions/treatments requires my specific authorization. WITHOUT THIS AUTHORIZATION, THIS INFORMATION WILL NOT BE RELEASED. I authorize the release of information relating to the following (INITIAL ALL THAT APPLY):

_____Sexually Transmitted Diseases/Infections (STD/STI)

_____HIV/AIDS

I UNDERSTAND THAT THIS AUTHORIZATON IS VOLUNTARY, AND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY WRITING TO THE ADDRESS ABOVE. ANY REVOCATION DOES NOT APPLY TO RECORDS ALREADY RELEASED IN GOOD FAITH PURSUANT TO THE ABOVE RELEASE. I UNDERSTAND THAT WHEN INFORMATION IS USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION, IT MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT I HAVE THE RIGHT TO INSPECT AND COPY THE INFORMATION BEING DISCLOSED PURSUANT TO THIS AUTHORIZATION. I UNDERSTAND THAT A MEDICAL PROVIDER TO WHOM THIS AUTHORIZATION IS FURNISHED MAY NOT CONDITION ITS TREATMENT OF ME ON WHETHER OR NOT I SIGN THE AUTHORIZATION, BUT IT HAS BEEN EXPLAINED TO ME THAT IF I DECLINE TO CONSENT TO THIS RELEASE OF INFORMATION, THE FOLLOWING CONSEQUENCES MAY APPLY, AS RELEVANT: MY PROVIDERS MAY BE UNABLE TO COORDINATE MY CARE; I MAY BE UNABLE TO APPLY FOR THIS PROGRAM; AND/OR THE REQUESTED RECORDS MAY NOT BE RELEASED. ANY COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.

Patient Signature: ____ Date signed: _________________________

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.