FirstLine Medical
6000 W Overland Rd
Boise, ID 83709
208-323-7588
208-515-3468 Fax

AUTHORIZATION TO
RELEASE INFORMATION

Patient: Name _____ Date of Birth _____
Address _____ Social Security#_____
City _____ State _____ Zip code _____
Day Phone Number _____ Email address _____

Clinic: Information to be released from: Clinic Name _____
Mailing Address _____
City/zip code _____

Recipient: Information to be released to: FirstLine Medical
6000 W Overland Rd
Boise, ID 83709

Please Fax Documents to; **208-515-3468 Fax**

Information to be disclosed: Medical Record Release Dates of Service Requested _____

- ☐ Clinic Visit Notes
- ☐ Special Tests _____
- ☐ Consultation/Follow-up Reports
- ☐ Immunizations
- ☐ Problems Lists
- ☐ Occupational Health/Worker's Comp
- ☐ X-Ray Report/Mammography Report
- ☐ Lab Reports
- ☐ X-Ray Films
- ☐ Hospital Reports
- ☐ Optical
- ☐ Mental Health/Psychological Testing/Reports
- ☐ Other _____
- ☐ Medical History
- ☐ **All the above** (including records relating to HIV, alcohol, drug treatment, records relating to communicable disease and/or those marked confidential).

Revocation: I understand that I may revoke this consent at any time and that the consent will automatically expire twelve months from the date of my signature.
I do not authorize further release to a third party. I understand that once information is released under this authorization, clinic and their employees and my physician(s) cannot prevent the redisclosure of that information.

Authorization: I authorize the above provider to release the information marked above to the recipient,

_____ _____
Signature of Patient/Guardian Relationship to Patient if signed by Guardian

_____ _____
Date of Patient's Signature Reason Patient Unable to Sign