REQUEST FOR MEDICAL RECORDS

SYRINGA HOSPITAL & CLINICS | 607 West Main Street • Grangeville, ID 83530 • (208) 983-1700 • 800-772-5137 • www.syringahospital.org

This authorizes release of medical records of

_____ _____/_____/_____
First Name Middle Initial Last Name Date of Birth

_____ _____
Address City State Zip Code Phone Number

Records requested from: _____ _____
Provider Name/Facility Phone Number

_____ _____
Address City State Zip Code Fax Number

Records to be sent to: **Syringa Hospital & Clinics** _____/_____/_____
Date records needed by
Mail to: 607 West Main St, Grangeville, Idaho 83530
Fax to: **208-983-8520** Phone: _____
Contact Person: _____

Dates of service to be included: _____ to _____ or ☐ previous two years of records

Purpose or need: _____

Information requested (check all that apply)

☐ Transfer of Care - Office Notes, History & Physical, Discharge Summary, Emergency Room, Lab, Radiology, Procedures, Test Results and Consultations for previous two years of treatment

☐ Hospital Records
☐ History & Physical
☐ Discharge Summary
☐ Operative Report
☐ Laboratory Reports
☐ X-ray Reports/Images
☐ Pathology reports
☐ Physician Orders
☐ Progress Notes
☐ Emergency Record
☐ Clinic Record
☐ Billing Statements
☐ Other: _____

* The following items must be initialed to be included in the use and/or disclosure of other health information:
_____*Mental health information and/or records _____*Alcohol, Drug or Substance Abuse Records

By signing this authorization form, I understand that:

- This authorization lasts for one year after the date signed unless you enter a different expiration date here: _____.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
- Any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- You are entitled to a copy of this authorization upon request.

_____ _____/_____/_____
Signature of Patient (or Patient's Legal Representative if applicable) Date

_____ _____
Print Patient's Name (or Patient's Legal Representative if applicable) Relationship to Patient