Dr. M. Cole Johnson, D.O.
Merrick Reynolds, PA-C
526 Shoup Ave. West Suite D, Twin Falls, ID 83301
Phone 208-733-1112 Fax 208-732-1212
(use area code when faxing even if local)

Authorization to Release Medical Information to Family Members and Consent to Treat

Many of our patients allow family members such as their spouse/significant other, parents (s), grandparents, guardians or other to call and discuss medical information, request prescriptions, vaccine information, medical records and results of tests, pick up forms, etc. Under the requirements of HIPAA we are not allowed to give this information to anyone without written consent. If you wish to have any of your medial information released to any other individuals you must sign this form. Signing this form will only give consent to release said information or consent to treat to the individuals listed below.

You have the right to remove this authorization at any time by so requesting in writing.

I, _____, date of birth_____,
(Print Patient Name)

Authorize representatives of Dr. M. Cole Johnson, D.O. & Merrick Reynolds, PA-C office to share and/or release information to:

1) _____ Relationship_____

Check all that apply:

O Regarding appointment, time & date **O** Discuss lab results **O** Discuss Vaccines

O Discuss medical care, an issue or concern **O** Request and pick up/fax prescriptions/forms

O Bring into the office for an appointment and consent to treat accordingly.

2) _____ Relationship _____

Check all that apply:

O Regarding appointment, time & date **O** Discuss lab results **O** Discuss Vaccines

O Discuss medical care, an issue or concern **O** Request and pick up/fax prescriptions/forms

O Bring into the office for an appointment and consent to treat accordingly.

3) _____ Relationship _____

Check all that apply:

O Regarding appointment, time & date **O** Discuss lab results **O** Discuss Vaccines

O Discuss medical care, an issue or concern **O** Request and pick up/fax prescriptions/forms

O Bring into the office for an appointment and consent to treat accordingly.

I understand that I have the right to change this authorization, in writing, at any time by sending a written notification to this office.

I understand that this consent excludes consent/authorization for immunizations. A parent/legal guardian must be present for all shots/immunizations. _____ (initial)

_____ _____

Print Name **Date**

_____ _____

Signature of Patient/Legal Representative **Relationship to patient if minor**