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 for Release of Patient Identifiable Health Information

Patient Name/Names____

DOB____________________ Phone#______________

1. I authorize the use or disclosure of the above named individual's health Information as described below.
2. Name of person or agency released **TO**: **Dr. M. Cole Johnson & Merrick Reynolds PA-C**

Address **526 Shoup Ave. West Suite D.** City **Twin Falls** State **ID** Zip **83301**
Phone: **208-733-1112** Fax: **208-732-1212**

Name of Person or agency information released **FROM:**______________________________
Address______________________________ City______________ State__________ Zip__________
Phone:____________________ Fax:____________________

3. Purpose of need for information:____

4. The type and amount of information to be used or disclosed is as follows: (includes dates where appropriate)
From (date)______________________________ To (date)______________________________

___ Discharge Summary ___Progress Notes ___ Diagnostic Image Reports Only ___ Billing Information

___ History and Physical exam ___Aftercare Plan ___ Diagnostic Image Film Copies ___ Physiological Exam

___ Laboratory Reports ___ Medication List ___ Immunizations Record ___ Entire Record

___ Pathology Reports ___Evidentiary Interview Summary

___ Consultation Reports From (Dr's Names)______________________________ ___ Other (Specify)__________________

5. I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to our Office Manager. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will **not** apply to my insurance company and as law proves my insurer with the right to contest a claim under my policy. This authorization will expire in 90 days unless otherwise specified. Unless otherwise revoked, the authorization revoked, the authorization will expire on the following dates, event or condition:______________________________
____
__________________.

AIDS/HIV, Alcohol and Drug Abuse Patient Information Authorization

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services and information protected by Federal regulation (42 CFR, part 2) and prohibits re-disclosure of records related to treatment of alcohol and drug abuse.

___ Substance Abuse ___ HIV (AIDS) results ___Psychiatric Evaluation & Assessment ___ Psychological studies

___ Not Applicable

Signature of Patient______________________________ Date______________________

When a patient is a minor or unable to give consent, signature of a person authorized to consent for a patient.

Signature of Legal Representative______________________ Date______________________

Signature of Witness______________________________ Date______________________