KANIKSU COMMUNITY HEALTH

WHOLE HEALTH FOR YOUR WHOLE LIFE

www.kchnorthidaho.org

Patient Name:_____**Date of Birth:** _____

Today's Date:_____

Please fill in the applicable boxes below to the best of your knowledge/memory.

Women age 21 through 64 years

Procedure	Who performed the procedure? (clinic / provider name)	Approximate Date	Results
PAP smear			

Women age 50 years and older

Procedure	Who performed the procedure? (clinic / provider name)	Approximate Date	Results
DEXA scan (bone density scan)			
Colonoscopy			
Sigmoidoscopy			
Stool card			
Mammogram			

Men age 50 years and older

Procedure	Who performed the procedure? (clinic / provider name)	Approximate Date	Results
Colonoscopy			
Sigmoidoscopy			
Stool card			

Please complete the **'Release of Information'** found on the back of this form. Please fill this out regarding any of the information provided above. Please ask for additional ROI(s) as needed if more than one location was named above.

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name_____DOB _____ SS#_____
Address_____Phone ( ) _____
I authorize (provider name and address_____to use and/or disclose my health information as identified below to:

□ Patient at the same address above □ Pickup □ Mail Paper Copy □ Fax □ Electronic Copy
□ Other (include name or office, address, phone, fax)

_____
_____

Purpose(s): □ At the request of the patient □ Doctor/Continued Care □ Attorney □ Financial
□ Other as noted _____

By initialing the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if such information exist:

_____ Please send the entire medical record (all information) to the above named recipient.
_____ **Medical /Dental records** from _____ to _____ _____ Billing Statements
_____ Laboratory and/or Pathology Reports _____Dental X-rays _____ Diagnostic Imaging Reports
_____ Other:

Federal regulations require a description of how much and what kind of the following information is to be disclosed. The following items must be individually initialed to be included in the use or disclosure of other health information: Federal law prohibits the re-disclosure of such information.

____ *HIV / AIDS related health information and/or records ____ *Sexually Transmitted Disease information and/or records
____ *Birth Control/Pregnancy information and/or records ____ *Drug/alcohol diagnosis, treatment and/or referral information
____ *Mental health information and/or records ____ *Genetic testing information and/or records
____ Other _____ ____ *Restricted protected health information
Agreement must be terminated in writing or documented oral agreement to restrict disclosure.

____ ***Psychotherapy notes** (If this authorization is for the use and/or disclosure of psychotherapy notes, then it cannot be combined with any other authorization.)

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer of Kaniksu Community Health. Unless revoked earlier, this authorization will expire 180 days from the date of signing or upon_____. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by federal privacy laws or regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations. I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

SIGNATURE of Patient _____ Date: _____
Printed Name _____
If other than Patient, indicated relationship: □ Parent □ Guardian □ Legal Representative □ Power of Attorney
Identity of patient and/or signature verified with: □ Photo ID □ Matching Signature □ Other _____
Verified by (print name): _____ Date: _____
Request completed by (print name) _____Date: _____

Please allow at least 5 business days for records to be prepared. There may be a charge for these purposes. A copy of this signed form can be provided to the individual and/or the individual's legal representative. An electronic copy may be obtained from our Patient Portal immediately.