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Release From: **(COMPLETE NAME & ADDRESS)**	Release To: Erland Internal Medicine, P.C. Keri Erland, MD 3667 N. Locust Grove Rd. Meridian, ID 83646

PATIENT NAME (PLEASE PRINT)_____ **DOB**_____

For the purpose of: ☐ **at the request of the patient** ☐ **at the request of the recipient** ☐_____

- ☐ Entire Record
- ☐ Most recent two year history
- ☐ Laboratory reports
- ☐ Diagnostic imaging reports
- ☐ Other (Specify) _____

By **initializing** in the spaces below, I specifically authorize the disclosure of the following information that may have additional state and federal protections:

_____ Mental Health Information

_____Drug/Alcohol Conditions

_____ HIV/AIDS Information

_____Genetic Information

Release of the above information is limited to:

_____Time Period_____

_____Treatment Dates_____

Disclosure Statement

I understand that once the information is disclosed pursuant to this authorization it may be re-disclosed by the recipient without the knowledge or consent of Erland Internal Medicine, P.C. or you. This information may not be protected by Federal privacy regulation. I understand that I do not have to sign this authorization. My refusal to sign this authorization will not affect my ability to receive health care services or reimbursement for services except in the circumstances that the health care services are sole for the purpose of providing health information to someone else and the authorization is necessary to determine if I am eligible to enroll in a health plan.

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 120 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request. Your general medical information may contain references to your mental state, drug and alcohol conditions, or HIV status or sexually transmitted diseases. Full release of this information requires additional authorized initials (see above). We make every effort to prevent release of this information. However, we cannot guarantee that every reference to these conditions has been removed from your general medical record. Please allow up to 30 days for processing of routine record releases.

_____ _____

Signature of patient or person authorized by law (required) **Date**