GEM FAMILY MEDICINE
and Pregnancy Care

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ **Date of Birth:** _____
This is to authorize that medical information regarding the above identified patient be released:

Records Released from: _____

Address: _____

Phone #: _____ Fax #: _____

Records Released to: **Gem Family Medicine and Pregnancy Care**
2020 S. Johns Avenue, Suite B, Emmett, ID 83617
Ph: (208) 369-4340 F: (208)369-4341

Copies of Records Requested: (Check all that apply)

☐	History and Physical	☐	Lab Report
☐	Discharge Summary	☐	Last Office Visit Note
☐	Operative Report	☐	Consultation Note
☐	Pathology Report	☐	EKG Report
☐	Radiology Report	☐	Complete Medical Chart
☐	ER Report	☐	Other: _____

Reason for Request: For Primary Care Provider

As a patient of Gem Family Medicine and Pregnancy Care, you are entitled under Federal Law to access your Personal Health Information (PHI). Your records are protected and cannot be disclosed without your permission.

_____ _____
Authorized Signature (Patient or Legal Guardian) **Date**

_____
Relationship to Patient (if Parent or Legal Guardian)