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Request for Protected Health Information

Patient: _____ Date of Birth: _____

Other Names Known As: _____

I authorize that my medical information be released:

Please Circle: To or From

Functional & Integrative Medicine of Idaho, PA
3858 N. Garden Center Way, Suite 100
Boise, ID 83703

208.385.7711 Phone
208.385.0346 Fax

Please Circle: To or From

Name: _____

Facility: _____

Phone: _____

Fax: _____

The following medical information is being requested:

Verbal Communication

Recent Records from: _____

Problem List/Medication List

Chart Notes from: _____

Labs: _____

Entire Chart

Other: _____

Comments: _____

I acknowledge that data to be released may include material that is protected by Federal Law and that it is applicable to any and all of the following: *substance abuse, mental health and/or HIV treatment information/test results*. My signature below authorizes release of all such information except as otherwise specified. This consent will expire in two years or upon my written request.

Signature: _____ **Date:** _____

If signing for a minor or a dependent, please state your relation: _____

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR, Part 2) prohibits you from making any further disclosure of this information, except with the specific written consent of the person to whom it pertains. A general authorization for the release of the medical or other information if held by another party is not sufficient for this purpose. Federal Regulations state that any person who violates any provision of this law shall be fined not less than \$500 in the case of the first offense and not more than \$5000 in the case of each subsequent offense.