

POLARIS MEDICAL

Direct Primary Care

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL RECORDS

Date: _____

Patient Name: _____ Date of birth: _____

Previous Name(s): _____

Release Information From:

Clinic/Physician: _____

Address: _____

Phone: _____ Fax: _____

Release Information To:

Clinic: **Polaris Medical, PLLC**

Address: **414 Church Street, Suite 120, Sandpoint, Idaho 83864**

Phone: **208.277. 9717** Fax: **208.435.1862** Email: **polaris@atlasmd.io**

Information to release:

All records past two years

All records

Other, please specify: _____

Purpose of Disclosure (Circle One): Legal Insurance Continuity of Care Personal

I, _____, hereby authorize the above named medical facility to release medical records to Polaris Medical, PLLC, including laboratory and radiology results, medications, hospital notes, office notes, and treatment plans.

- I understand that this authorization will expire in 6 months, but that it may be revoked at any time in writing. I acknowledge that my records may include sensitive material, such as psychiatric, drug/alcohol or HIV/AIDS/sexually transmitted disease records along with other information continued in the medical record.
- I understand that I am giving permission to disclose these confidential healthcare records to Polaris Medical, PLLC and that those records and information released may be subject to re-disclosure by the recipient and may no longer be protected un federal privacy regulations.

Signature of Patient or Legal Guardian

Relationship to patient