BOUNDARY Community Clinics
a division of Boundary Community Hospital

Request that Medical Records from Another Healthcare Provider be sent to Boundary Community Clinics

Please print clearly, otherwise your request may be revoked or delayed.

For the Patient(s) identified in the list below: I_____ (name);
Address and Phone: _____ authorize

Name of Healthcare
Provider or Facility: _____
Complete Address: _____
_____
Phone and Fax: _____

to release the standard set of medical records (immunization record, medication list, problem list, most recent well visit physical exam, consultant notes, lab work, radiology and other information important to the patient's ongoing care) to:

Boundary Community Clinics
6641 Kaniksu Street
Bonners Ferry, ID 83805

Phone: (208) 267-3655
Fax: (208) 267-3757

Patient Name	Date of Birth	Dates of Service
_____	_____	_____
_____	_____	_____
_____	_____	_____

Purpose of Request: ☐ Personal Use ☐ Transfer of Care ☐ Other

As the person signing this authorization, I understand that I am giving my permission to the disclosure of confidential healthcare records to include, if applicable, Psychiatric, Drug/Alcohol or HIV Testing/Treatment records and other information contained in the medical record, unless otherwise indicated under my special instructions written below.

I understand that I have the right to revoke this authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I also understand that my revocation may not be effective if I lack the capacity to sign the revocation, if a licensed provider determines that the revocation is reasonably likely to cause serious harm to me or other persons, or when the revocation is not permitted by law.

If you prefer the entire record, instead of the standard record release described above, please initial: _____

Special Instructions (none if blank): _____
_____.

This authorization is only valid for the information/purpose indicated above and expires 180 days (6 months) from signature date unless otherwise indicated on this authorization.

X
_____ Date: _____
Signature of Patient or Legal Representative

If signing as Legal Representative, indicate relationship to patient:_____