PH: (208) 375-0722
FAX: (208) 375-0015

2036 N. COLE RD.
BOISE, ID 83704

WWW.NCIDAHO.COM

Request for Release of Confidential Medical Information

Records From:

Neighborhood Clinic
2036 N. Cole Rd.
Boise, ID 83704

Records To:

____
MD or Group Name

____
Mailing Address or Fax Number

____
City, State, & Zip Code

Patient Information:

Name: _______________________________________

Date of Birth: _________________________________

Contact Phone Number: __________________________

Purpose of Release: □ Transfer of Care □ Personal Use □ Insurance □ Legal Request □ Other

Please Send: □ All Records **OR** Date Range**:** From _________ To __________

I hereby request and authorize the release of requested medical information from the above-named party to the corresponding above-named party. I understand the information I authorize to be released may include STD's, Mental Health and Substance Abuse and be subject to re-disclosure by the recipient.

_____________________________________ ________________
Patient or Guardian Date

____
If Guardian, Relationship