Bella FAMILY HEALTHCARE & AESTHETICS
1545 E Leighfield Dr Meridian ID 83646 208.957-6871 Fax 208.957-6872

Medical Records Release

Patient Name: _____ Date of Birth: _____

Previous Name: _____ Daytime Phone: _____

Please check one:

I request Bella Family Healthcare & Aesthetics: ☐ Release To ☐ Obtain From

Name: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip _____

You may use or disclose the following health care information (check all that apply):

☐ Chart Notes-Most Recent Visit ☐ Patient Visit Summary

☐ Labs/Pathology-Previous Year to date ☐ Most Recent Specialist(s) Visit

☐ X-Rays/Diagnostics-Previous Year to date ☐ Last Well Child Check

☐ Immunizations

Other:_____ Time Frame Requested:_____

☐Pick up, where_____ ☒ Fax ☐ Mail ☐Emailed to _____

Reason for Authorization: ☐At request of individual ☐Other:_____

Expiration: ☐Date:_____or ☐ Event (one-time release):_____

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my consent to use or disclosure of my protected healthcare information for purposes of treatment, payment, or health care operations. I may inspect or copy any information used/disclosed under this authorization. I have authorized Bella Family Healthcare & Aesthetics to photocopy this authorization, and you may accept a photocopy of this authorization as if it were the original. I understand that I may revoke this authorization in writing at any time to Bella Family Healthcare & Aesthetics, except to the extent that the information has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in 12 months unless otherwise dated above.

SPECIFIC AUTHORIZATION

I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have marked no and initialed it.

YES ☐ NO ☐ INITALS:_____

_____ _____ _____

Signature/Legal Responsible Party Relationship to Patient Date