

MEDICAL RECORDS RELEASE

**AUTHORIZATION FOR USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

Patient Name: _____

Date of Birth: _____

I hereby authorize R. Timothy Thurman, M.D. to use and disclose my individually identifiable **Protected Health Information (PHI)** in the manner described below. I understand that my PHI may be redisclosed by the person or entity receiving my PHI from R. Timothy Thurman, M.D. and that it may then no longer be protected by federal privacy regulations. State law may or may not prohibit such redisclosure by the person or entity receiving my PHI from R. Timothy Thurman, M.D. I voluntarily sign this authorization and I understand that my health care will not be affected if I do not agree to sign this form.

I authorize my PHI to be used and disclosed, and/or obtained by R. Timothy Thurman, M.D. for whatever is necessary for my treatment and care. I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying R. Timothy Thurman, M.D. in writing. I understand that my revocation of this authorization will not affect any actions taken by R. Timothy Thurman, M.D. in reliance on this authorization before my request has been received for revocation.

To revoke this authorization, a written, signed request must be sent to:

**R. Timothy Thurman, M.D.
933 S. Utah Ave.
Idaho Falls, ID 83402**

Signature: _____ Date: _____

Relationship if minor: _____