REQUEST TO COPY OR INSPECT
PROTECTED HEALTH INFORMATION

Gem State
DIRECT PRIMARY CARE

_____ _____
Patient Name/Previous Name(s) Date of Birth

_____ _____
Street Address, City, State, Zip Code Phone Number

Release my protected health information to: ☐ Myself ☐ Individual Noted Below

_____ _____
Individual Name Business Office Name (If Applicable)

_____ (__)_____(___)_____
Street Address, City, State, Zip Code Phone Number & Fax Number

Information to be Disclosed

Date(s) of Service: _____ ☐ Entire Medical Record

☐ History and Physical ☐ Diagnosis ☐ Laboratory/Pathology
☐ Progress Notes ☐ Treatment Plan or Summary ☐ Medication Information
☐ Continuing Care Plan(s) ☐ Demographic Information
☐ Other: _____

EXCLUDE the following information from the records released: ***(please initial)***

_____ ☐ Drug/Alcohol abuse/treatment and diagnosis _____ ☐ Sexually transmitted disease
_____ ☐ Mental Illness or psychiatric diagnosis and treatment _____ ☐ HIV/AIDS

We may be prohibited from making certain information available to you or to your representative, including:

-Psychotherapy notes
-Information related to medical research in which you have agreed to participate
-Information related to legal proceedings
-Information obtained under a promise of confidentiality
-Information that federal or state laws prevent us from disclosing
-Information for which the disclosure may result in harm or injury to your or to another person

This information is to be: ☐Mailed ☐Pickup ☐ Fax ☐ Email: _____
Please choose format: ☐ Paper Copy ☐ Email ☐ Fax

This authorization shall be in force and effect for 1 year from date of signature or until _____(date).

YOUR RIGHTS WITH RESPECT TO THIS REQUEST: Within the limitations of law, we will make every effort to accommodate your request. We will complete our review of your request and as requested either provide a copy or arrange for you to inspect your records within 30 days of your request or provide
you with a written explanation of any restriction on the information that we can provide you.

_____ _____
PRINTED NAME OF PATIENT/LEGAL REPRESENTATIVE RELATIONSHIP TO PATIENT

_____ _____
SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE DATE

Mailing Address: 8152 N Wayne Dr, Hayden ID 83835 or Fax: 208-415-4805