STUDENT HEALTH SERVICES
LEWIS-CLARK STATE COLLEGE
500 8TH AVENUE
LEWISTON, ID 83501
(208) 792-2211

Request for Release of Medical Records

Patient Name	Date of Birth	Phone number

Release records from:

MD or Group Name or Individual	
Mailing Address	
City, State, Zip Code	

Important: Please enclose a copy of release form with records to student health.

Release records to:

MD or Group Name or Individual	
Relationship if other than Health Care Provider	☐ Spouse ☐ Parent ☐ Significant Other ☐ Interpreter ☐ Friend ☐ Other____
Mailing Address	
City, State, Zip Code	
Date Requested	
Appointment Date	

The information I request to be released is:

☐ All Medical Records
☐ Progress Notes
☐ History & Physical Exam
☐ Consultation
☐ Other: _ ____
☐ Mutual Exchange of Information
☐ AIDS/HIV Related Data
☐ Medical Excuse / Release
☐ X-Ray Reports
☐ EKG Report
☐ Laboratory Reports

The date(s) of records that I request to be release is:

☐ All Dates ☐ Selected Dates: From: ________________________ To:_________________________

Disclosure:

"I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted infection, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released."

"I understand that LCSC Student Health Services cannot limit or control the subsequent use or dissemination of medical information by the party to whom I request the information be furnished. This is a free and voluntary act by me. I understand that my records may be faxed if there is not time to mail them. I hereby release LCSC Student Health Services and its staff from all legal responsibility that may arise from the release of the medical information hereby authorized."

THERE IS NO CHARGE WHEN RECORDS ARE SENT TO A PHYSICIAN FOR CONTINUING CARE. A COPYING FEE IS CHARGED WHEN RECORDS ARE RELEASED TO A PATIENT OR OTHER NON-PHYSICIAN RECIPIENT.

Authorization:

Patient Signature: _______________________________________ Date: _________________________

If minor, parent/guardian signature: _______________________________________ Date: _________________________

A photo copy of this authorization shall be considered as effective and valid as the original.
AUTHORIZATION IS VALID FOR 90 DAYS.
PLEASE ALLOW 5 WORKING DAYS FOR COPYING AND PREPARING RECORDS