AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize and direct any hospital, physician or other person who has any information regarding my medical care and treatment during _____, 20___ to _____, 20___, to release any and all medical records, reports and/or information to the Idaho State Board of Medicine or to such other representative of the Idaho State Board of Medicine as may be designated, for examination and for copying thereof, upon request for such records, reports or information for the specific purpose of addressing concerns relevant to my medical care and treatment.

I further authorize any hospital, physician or other person who has such information to consult with or discuss such information with any of the above entities or persons.

I further consent that a photocopy of this Authorization may be used in lieu of the original hereof and shall be considered valid for one (1) year from the date of my signature below. This authorization, however, is revocable upon receipt of my written request by the Idaho State Board of Medicine.

DATED This ____ day of _____, 20___.

_____
(Printed Name)

_____
(Signature)