J. Sorin Ispirescu, M.D. Leslie Rogers, FNP-C Madison Guzman, PA-C Matthew Hansen, PA-C

Patient Date of Birth:



Graham Andrews, FNP-C Amber Farance, PA-C Taylor Thomas, FNP-C

P. 208.263.9757

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MEDICAL RECORDS RELEASE

| records. | hereby consent to the release of my medical |
|---|--|
| I understand my records will be released TO / FROM: Person/Entity | |
| Address | |
| Phone Number/Fax Number | |
| Records that will be released are: (please check al Notes for all dates of service in our office Notes for a specific date of service: | l that apply) |
| I understand and acknowledge that if none of the above options are checked then my complete record will be disclosed. I understand that this authorization will remain in force until revoked by me in writing. | |
| Specific Authorization for HIV/AIDS Testing, Drug and Alcohol, and Mental Health Records: I acknowledge that the records to be released MAY include material that is protected by Federal Regulation 42 CFR, part 2 and is applicable to the above. My signature below authorizes the release of all information. Check here to suppress disclosure of this type of information: [] | |
| | nd authorize the release of said medical records person/entity. I understand that these records are my permission. |
| Signature of Patient (or other responsible party) | Date |