Authorization for Release of
Individually Identifiable Health Information

I hereby authorize the release of my individually identifiable health information as described below.

Patient's Name ______

Social Security # ______ **Date of Birth** ______

Person/organization authorized to release information: ______
(Health Care Provider)

To: **CANYON COUNTY PROSECUTING ATTORNEY'S OFFICE**
C/O ______
1115 Albany Street
Caldwell, Idaho 83605

Individually identifiable health information to be released: Any and all information of a medical nature, for dates of service (month/year) from ______ to ______ , including, but not limited to: pertinent record set, discharge summary, history and physical, consultation report, procedure report, pathology report, emergency services report, laboratory reports, radiology reports, orders/progress notes, and/or billing records contained in the patient's medical file and any other medical information requested by the Canyon County Prosecuting Attorney's Office. I also hereby provide specific authorization for the release of the following information:

	Initial
Mental health evaluation treatment	
AIDS/HIV - related treatment	
Substance abuse treatment	

Specific purpose of the disclosure: Criminal Prosecution Case of ______ (Defendant), Case No ______

I hereby release ______ and others including but not limited to Canyon County, a political subdivision of the State of Idaho, and any and all other officers, employees, volunteers, agents, insurers and any elected or appointed officials of Canyon County from any liability or damage which may result from furnishing, receiving, or releasing of the information requested. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

This authorization will automatically expire one year from the date signed.

Information About Your Rights
I have read and understand the following statement about my rights:
- I may revoke this authorization at any time prior to its expiration date by notifications to the Health Care Provider and Canyon County Prosecuting Attorney's Office in writing, but revocation will have no effect on any actions taken by the Health Care Provider and Canyon County Prosecuting Attorney's Office before it received such revocations.
- I may see and copy the information described on this form if I ask for it in writing.

I have read this form, or it has been read to me, and I understand its content.

______
Signature of Patient/Guardian/Legal Representative
(Patient a minor or unable to sign)

______
Date

______
Please print full name

SUBSCRIBED AND SWORN to before me this
_____ day of ____________________,

______
Notary Public, State of Idaho
Residing at: ____________________
Commission Expires: ____________________