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Experience You Can Trust  
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**AUTHORIZATION TO RELEASE INFORMATION**

Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip

Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_ Medical Records# \_\_\_\_\_

I authorize \_\_\_\_\_ to release medical information from my medical records to:

Name of Doctor, Hospital, Etc. that records are going to \_\_\_\_\_

Address \_\_\_\_\_

City/State/ZipCode \_\_\_\_\_

Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Fax ( \_\_\_\_\_ ) \_\_\_\_\_

**Please specify how records should be provided:**

\_\_\_\_\_ Mail \_\_\_\_\_ Fax \_\_\_\_\_ You will pick up

For the purpose of review/examination, I further authorize you to provide such copies thereof as may be requested. The foregoing is subject to such limitations as indicated below:

\_\_\_\_\_ Entire records in chart \_\_\_\_\_ X-Rays \_\_\_\_\_ Specific Information

I give special permission to release any information regarding (initial on line(s) below that you grant us permission to release the information to the above.)

\_\_\_\_\_ Substance Abuse \_\_\_\_\_ Psychiatric/Mental Health Information \_\_\_\_\_ HIV Information

Reason for request \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(if not patient, state relationship)

**FOR OFFICE USE**

\_\_\_\_\_ (Date ready) \_\_\_\_\_ (Staff initial-when picked up) \_\_\_\_\_ (Date picked up)