Idaho Independent Assessment Services Program
8850 W. Emerald St. - Suite 164| Boise, ID 83704 | 208.258.7980 | Fax: 208.258.7985

PROTECTED HEALTH INFORMATION RELEASE ACCESS REQUEST FORM

I hereby authorize Liberty Healthcare Corporation Independent Assessment Program and the Idaho Department of Health and Welfare to

☐ **DISCLOSE** and/or ☐ **RECEIVE** **[check one or both]** records for:

Applicant name: ____ DOB: ____________________________

From/To: ____ Phone: ___________________________

Address:

The following information: [Check all that apply]

☐ Comprehensive Diagnostic Assessment (CDA)
☐ CANS 100 Results
☐ Psychological Evaluation
☐ Safety Plan
☐ Physician Note
☐ Hospitalization Records
☐ Notice of Determination
☐ ICANS Portal Authorization
☐ Other _____________________________________

Conditions- I understand that Liberty Healthcare Corporation will not condition my assessment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have consequences including, but not limited to impacting the outcome of coordinated care. I understand that treatment and payment may not be conditioned on this authorization.
Please Note- Medical records may contain sensitive information including, but not limited to: Alcohol, Drugs, Mental Health, HIV/AIDS, and Sexually Transmitted Diseases.

Purpose- The purpose of this disclosure of information is to improve comprehensive assessment and share information relevant to assessment and when appropriate, coordinate treatment services.

Revocation- I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Liberty Healthcare Corporation Independent Assessment Program at 8850 W. Emerald Street, Suite 164, Boise, ID 83704. I further understand that a revocation of the authorization is not effective to the extent that action has already been taken in reliance on the authorization.

Form of Disclosure- Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure- I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

Expiration- This authorization will expire in one year, unless another date or event is specified here: ______________

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Printed Name and Signature of Applicant Date

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Printed Name and Signature of Parent or Legal Guardian Date