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**Patient Release Form
Authorization to Release Protected Health Information**

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

I, _____ authorize the following facility:
(insert your name)

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: : _____

to release my protected health information to:

Main Family Medical - David L. Gee, M.D.
203 W. Main St. Boise, ID 83702
Phone: (208) 336-7722
Fax: (208) 336-9284

This request applies to my:

- Complete medical record
- Healthcare information limited to the following conditions or dates:

Reason/Purpose for disclosure:

- Medical
- Legal
- Financial
- Personal

I have read and understood the information in this authorization.

Patient/Guardian Signature: _____ Date: _____