Liberty Healthcare Corporation
THE FREEDOM TO SUCCEED™

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 to **disclose AND/OR [circle one] receive** records for:

Applicant name:_____ DOB:_____
From/To:Innovative Health Care Concepts Phone:208-523-6727
Address: 115 E. 16th. St. Idaho Falls, ID 83404

The following information: [Check all that apply]

X Comprehensive Diagnostic Assessment (CDA)	X CANS-100 Results	____Psychological Evaluation
____ Neuropsychological Evaluation	____Physician Note	____Hospitalization Records
X Notice of Determination	X 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. 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- Unless sooner revoked, this authorization expires in one (1) year on the following date: 1 year from today **, or as otherwise indicated:**_____**.**

_____
Printed Name and Signature of Applicant Date

_____
Printed Name and Signature of Parent or Legal Guardian Date