RISE UP
Teen & Child Crisis Center of East Idaho

Authorization for Release of Health Information

Member Name_____ **Date of Birth**_____

This authorization expires in six months **unless noted otherwise**:

☐In one year ☐On date: _____

The person named above is or has been a patient of:

Rise-Up
Teen & Child Crisis Center
1140 Science Center Dr.
Idaho Falls, ID 83402
Phone: 208-826-0994 Email: ybhcccdirector@gmail.com Fax: 208- 845-6801

The person named above hereby authorizes_____ to
Name of Person, Provider, or Facility

☐Request health information from ☐Send health information to ☐Discuss health information with

The person named above authorizes information to be requested or release by representatives of:

Name of Person/
Provider/Facility: _____

Address: _____

Phone: _____

Fax: _____

Scope:

☐ All information regarding assessment, diagnosis, and treatment of member's condition, concern, or disease (specify): _____

☐ All information regarding care received by member the dates of:
_____ and _____
Starting Date Ending Date

☐ Other information (specify): __Coordination & Continuity of Care_____

Authorization

_____
Printed name of Member & Authorized Representative

_____ _____ _____ _____
Signature of Parent Or Authorized Representative | Date | Signature of witness | Date

9.1.23