CENTRAL MONTANA MEDICAL CENTER
Lewistown, Montana

AUTHORIZATION FOR DISCLOSURE OF EMPLOYEE HEALTH RECORDS

Employee/Former Employee Name:_____DOB:____/____/____
Printed name Date of Birth

Employee/Former Employee Address:_____
Street Address/PO Box

_____
City, State, Zip

I hereby authorize CMMC Employee Health to disclose my Employee Health Record to the following:

Name: _____

Attn: _____

Address: _____

_____

Telephone or Fax number:_____

I am requesting the following information: * (check appropriate boxes)

- ☐ Entire Employee Health record or specifically those parts selected below:
- ☐ PPD/TB Record
- ☐ Hepatitis B Immunization Record
- ☐ MMR Immunization Record
- ☐ Other:_____

Purpose of Disclosure:_____

- I understand that I may inspect or obtain a copy of my Employee Health records to be disclosed.
- **I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may no longer be protected by federal privacy laws or regulations.**
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Employee Health Department. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- **The facility, it's employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.**

This authorization will expire:_____
Date or Event

If I fail to specify an expiration date or event, this authorization will expire six (6) months from the date on which it was signed.

_____ ____/____/____
Signature of Employee Date

_____ ____/____/____
Witness** Date

_____ ____/____/____
Witness (2nd witness required for phone authorization) Date

*** Submit form to CMMC Employee Health Services, or fax directly to: (406) 535-6242**
**** The form will be witnessed at the time of record release, or by telephone, if faxed request.**