



# Authorization to Disclose Protected Health Information

<b>Patient Information</b>	Name: _____ Date of Birth: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____						
<b>Hospital/Clinic/Health Care Provider</b> (Who has the information you want released? Please list the specific hospital and/or clinic.)	Facility Name: _____ Phone: _____ Fax: _____ Facility Name: _____ Phone: _____ Fax: _____						
<b>Receiving Party</b> (Where do you want the information sent? Who may have the information?)	Name: _____ Address: _____ Day Phone: _____ City: _____ Fax Number: _____  Self Purpose of Record Release:						
<b>Information to be Released</b> (What do you want sent or released? Check the appropriate box.)	Date range of information to be released: From: _____ To: _____ Month/Year Month/Year Please check specific information to be released: <input type="checkbox"/> Provider reports _____ <input type="checkbox"/> Discharge Summary/Instructions <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Immunizations <input type="checkbox"/> Emergency Record <input type="checkbox"/> Pathology Reports <input type="checkbox"/> Billing <input type="checkbox"/> Other _____ <input type="checkbox"/> Imaging <input type="checkbox"/> reports <input type="checkbox"/> films/CD <input type="checkbox"/> Entire Record						
<b>Release Instructions</b> (How and when do you want the information?)  <b>Note:</b> *Fees may be charged in accordance with Federal and State law	Date information is needed: _____ Disclosure Method: <input type="checkbox"/> Pickup <input type="checkbox"/> Mail <input type="checkbox"/> email <input type="checkbox"/> CD <input type="checkbox"/> Fax # _____ Email Address _____ <input type="checkbox"/> Other _____ Please be aware that unencrypted email is not secure and may expose your protected health information (PHI) during transmission. By choosing this option, you acknowledge and accept these risks.						
<b>Purpose of Release</b> (Why records are needed)	<input type="checkbox"/> Patient request <input type="checkbox"/> Transfer of care <input type="checkbox"/> Follow-up care <input type="checkbox"/> Continuing Care <input type="checkbox"/> Litigation/Legal <input type="checkbox"/> Insurance Payment/Claim <input type="checkbox"/> Other _____						
By signing this authorization form, I understand that:							
<ul style="list-style-type: none"> <li>● The information in the health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) and genetic information. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.</li> <li>● This authorization does not apply to psychotherapy notes.</li> <li>● Once the information described herein is disclosed, it could be redisclosed by the recipient and may not be protected by privacy protections.</li> <li>● I have the right to revoke this Authorization at any time. Revocation must be in writing and presented to Health Information Management (fax 406-535-4696). Revocation will not apply to information that has already been disclosed in response to this Authorization.</li> <li>● Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.</li> <li>● Requests for copies of health records are subject to reproduction fees in accordance with Federal and State law.</li> <li>● I will receive a copy of this Authorization.</li> <li>● Unless otherwise revoked, this Authorization will expire on the following date: _____. If I fail to specify an expiration date/event/condition, this Authorization will expire 1 year from the date it is signed.</li> </ul>							
<table style="width:100%; border: none;"> <tr> <td style="width:40%; border: none;">_____ Signature of Patient or Legal Representative</td> <td style="width:30%; border: none;">_____ Printed Name</td> <td style="width:30%; border: none;">_____ Date</td> </tr> <tr> <td style="border: none;">If Signed by Legal Representative, Relationship to Patient</td> <td style="border: none;">_____ Signature of Witness</td> <td style="border: none;">_____ 2nd Witness Signature</td> </tr> </table>		_____ Signature of Patient or Legal Representative	_____ Printed Name	_____ Date	If Signed by Legal Representative, Relationship to Patient	_____ Signature of Witness	_____ 2nd Witness Signature
_____ Signature of Patient or Legal Representative	_____ Printed Name	_____ Date					
If Signed by Legal Representative, Relationship to Patient	_____ Signature of Witness	_____ 2nd Witness Signature					
<b>For Office Use Only:</b> Signature/ID verified <input type="checkbox"/> Yes <input type="checkbox"/> No      Completed by (Name/Date) _____ # of pages released _____      MRN/Log #: _____							
<b>Revocation Authorization</b>	I hereby revoke (cancel) this Authorization to Disclose Protected Health Information. Cancellation Signature: _____ Date: _____						