Authorization to Disclose Protected Health Information

CENTRAL MONTANA MEDICAL CENTER

Patient Information	Name: _____ Date of Birth: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____
Hospital/Clinic/Health Care Provider (Who has the information you want released? Please list the specific hospital and/or clinic.)	Facility Name: _____ Phone: _____ Fax: _____ Facility Name: _____ Phone: _____ Fax: _____ Facility Name: _____ Phone: _____ Fax: _____
Receiving Party (Where do you want the information sent? Who may have the information?)	Name: _____ Address: _____ Day Phone: _____ City: _____ Fax Number: _____ ☐ Self Purpose of Record Release:
Information to be Released (What do you want sent or released? Check the appropriate box.)	Date range of information to be released: From: _____ (Month/Year) To: _____ (Month/Year) Please check specific information to be released: ☐ Provider reports _____ ☐ Discharge Summary/Instructions ☐ Laboratory Reports ☐ Immunizations ☐ Emergency Record ☐ Pathology Reports ☐ Billing ☐ Other _____ ☐ Imaging ☐ reports ☐ films/CD ☐ Entire Record _____
Release Instructions (How and when do you want the information?)	Date information is needed: _____ Disclosure Method: ☐ Pickup ☐ Mail ☐ email ☐ CD ☐ Fax # _____ Email Address _____ ☐ Other _____ **Note:** *Fees may be charged in accordance with Federal and State law.
Purpose of Release (Why records are needed)	☐ Patient request ☐ Transfer of care ☐ Follow-up care ☐ Continuing Care ☐ Litigation/Legal ☐ Insurance Payment/Claim ☐ Other _____

By signing this authorization form, I understand that:

- 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.
- This authorization does not apply to psychotherapy notes.
- Once the information described herein is disclosed, it could be redisclosed by the recipient and may not be protected by privacy protections.
- 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.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Requests for copies of health records are subject to reproduction fees in accordance with Federal and State law.
- I will receive a copy of this Authorization.
- 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.

_____	_____	_____
Signature of Patient or Legal Representative	Printed Name	Date
_____	_____	_____
If Signed by Legal Representative, Relationship to Patient	Signature of Witness	Printed Name

For Office Use Only:

Signature/ID verified ☐ Yes ☐ No
# of pages released _____

Completed by (Name/Date) _____
MRN/Log #: _____

Revocation Authorization	*I hereby revoke (cancel) this Authorization to Disclose Protected Health Information.* *Cancellation Signature:* _____ *Date:* _____