Central Montana Medical Center
408 Wendell Avenue
Lewistown, Montana 59457
406-535-6247 Health Information Management Dept

Authorization/Request for Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____
Please Print

Patient Address: _____ Phone Number: _____
Street Address/PO Box

_____
City, State, Zip Code

I hereby authorize _____ to disclose my Protected Health Information (PHI) to the following person/organization:

Name: _____

Address: _____

_____

Telephone and/or Fax Number: _____

The following information is requested:

Dates of Service: _____

Check appropriate boxes for your entire Medical record/ or portions of the record

☐ **Entire Medical Record(s)**

☐ **Discharge Summary**	☐ **Radiology Reports**
☐ **History and Physical**	☐ **Laboratory Reports**
☐ **Consultation Report**	☐ **Operative Report**
☐ **Emergency Room Report**	☐ **Physician orders**
☐ **Psychotherapy Notes**	☐ **Cardiology Reports**
☐ **Physician Progress Notes**	☐ **Radiology Disc**

☐ **Other** _____

Purpose of Disclosure: _____

I understand that I may inspect or obtain a copy of my PHI to be disclosed.

I understand that the information in my health record may include information relating to alcohol, drug abuse, mental health records, and /or other highly confidential information obtained during the course of my diagnosis and treatment.

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I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

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 CMMC Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

The facility, its 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 Patient or Legal Representative Date Time

_____
If other than patient – relationship

_____ _____/_____
Witness Date Time

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

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