

Authorization to Disclose Protected Health Information

Patient Information	Name:	Date of Birth:	
	Address:	Day Phone:	
		State:	
Hospital/Clinic/Health Care Provider (Who has the information you want released? Please list the specific hospital and/or clinic.)	Facility Name:		Phone: Fax: Phone: Fax:
Receiving Party (Where do you want the information sent? Who may have the information?)	Name: Day Phone: Day Phone: Self Purpose of Record Release:		
Information to be Released (What do you want sent or released? Check the appropriate box.)	Please check specific information Provider reports Discharge Summary/Instruct Emergency Record		(Month/Year) Immunizations
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:			
Signature of Patient or Legal Representative Printed Name Date			
If Signed by Legal Representative, Relationship to Patient			
For Office Use Only: Signature/ID verified Yes No # of pages released		Signature of Witness Pri	nted Name
Revocation Authorization	I hereby revoke (cancel) this Author Cancellation Signature:	ization to Disclose Protected Health Infori	mation. Date: