AUTHORIZATION FOR RELEASE OF INFORMATION

***** IMPORTANT: In order for authorization to be valid ALL areas must be completed *****

_____ _____ _____ _____ _____/__/_____

Patient Last Name **First Name** MI **Date of Birth** **Social Security Number**

_____ _____ _____ _____ _____

Patient Address (PO Box/Street) **City** **State** **Zip** **Daytime Telephone Number**

I AUTHORIZE THE FACILITY BELOW TO RELEASE MY PROTECTED HEALTH INFORMATION:

□ Missoula Surgical Associates
□ Western Montana Clinic
□ Other

_____ _____
Healthcare Provider Name Telephone/Fax Number

_____ _____
Address City/State/Zip

Information to be Released (Check all that apply)

□ Only medical records from (name of provider) _____
□ Past (circle one) 2 3 5 years
□ Only dates of service from _____to_____
□ Information from medical record for the completion of a disability form
□ All medical records
□ Other _____

The medical record includes all health care information, whether oral or recorded in any form or medium that identifies the patient or can readily be associated with the patient and relates to the patient's care. This includes all health care information in your/our possession, whether generated by you/us or any other source, as well as health care information associated with drug/alcohol abuse, mental or psychiatric care, abortion, and HIV status and/or diagnosis of AIDS and/or other sexually transmitted diseases including hepatitis.

The following WILL NOT be released unless you indicate your specific authorization by initialing each appropriate category:

_____Drug/Alcohol Abuse _____Aids/HIV Related Information _____Genetic _____Behavioral or Mental Health Issues

Party to receive the information

Facility / Person Name _____

Address _____

City _____ State___ Zip_____

Fax Information: □ YES □ NO Fax Number:_____ (maximum of 15 pages)

Reason for Request: ___Legal ___Moving ___Review Own Records ___Insurance Claim ___Changing Physician
___Other _____

If one of the above facilities is requesting this authorization be completed, an individual has the right not to sign with the understanding that an individual's health care and the payment for health care will not be affected.

I understand that this authorization may be revoked by me at any time, provided that I do so in writing and submit it to the Medical Records Department, up to the extent that the disclosure has not already been made. I also understand that my protected health information may be re-disclosed by the recipient and no longer be protected under federal law. Authorization will expire in 12 months unless otherwise specified below.

_____ _____ _____

Patient Signature (if over 18) **Date** **Expiration Date** **(Not to exceed 30 months)**

OR

_____ _____ _____

Legal Representative/Guardian **Date** **Relationship to Patient**

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