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
				xxx / xx /

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
□ Other

_____ _____
Healthcare Provider Name Telephone/Fax Number

_____ _____
Address City/State/Zip

Information to be Released (Check all that apply – the minimum necessary for your purposes)

□ All medical records
□ Only medical records from (name of provider) _____
□ Only dates of service from _____to_____
□ Information from medical record for the completion of a disability form
□ Ultrasound films
□ 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_____

Delivery Method

☐ MyChart

☐ Email: _____

☐ *Secure email* ☐*Unsecure email*

☐ Fax (15 page max): _____

☐ Mail

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 6 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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MISSOULA SURGICAL ASSOCIATES

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Instructions for Completing the Authorization for Release of Information Form

***** IMPORTANT: ALL Sections must be completed for the request to be valid and processed *****

- Provide the patient's identifying information as completely as possible.
- Mark the facility you are requesting records FROM. Use "Other" only if you are using this form to obtain records from an outside facility at the request of a Missoula Surgical Associates (MSA) provider.
- Mark the best description for the minimum necessary records for your purposes. For instance, most providers do not want your entire record. Be as specific as you are able.
- Some types of information have extra restriction; please initial next to each restricted record type you wish to have included in your request.
- Indicate who is to receive the records. If you are requesting records from an outside facility, please indicate which MSA provider is to receive the records. We MUST have an address, email address, or FAX number in order to fulfill the request. If contact information is missing, your request may be delayed.
- Note the reason for the request.
- Sign and date the form. If the patient is under 18 years, a legal guardian must sign and indicate their relationship to the patient.
- If you choose, indicate a date after which your authorization is no longer in effect. This date can be no more than 30 months from the date of signing. The authorization will automatically expire after 12 months.