PIONEER MEDICAL CENTER
P.O.Box.1228, Big Timber, MT
406-932-4603 Fax: 406-932-5468

AUTHORIZATION TO DISCLOSE PRIVATE HEALTH CARE INFORMATION

✓ **(Please note: ALL information identified by a check MUST be completed)**

✓ **Name of Patient:**_____ **Phone:**_____ **MR#:**_____

✓ **Date of Birth:**_____ **or Social Security Number:**_____

✓ **I authorize Pioneer Medical Center or** _____ **to use or disclose my (name of patient above) private health care information as described below. The type and amount of information to be used or disclosed is as follows: (please circle those that apply):**

HEALTH CARE INFORMATION NEEDED	HEALTH CARE INFORMATION NEEDED
▪ Entire medical record	▪ X-ray Results
▪ Hospital visit	▪ X-ray Films
▪ Clinic visit	▪ Lab Result
▪ Immunization Record	▪ HIV Test Results
▪ Other	▪ A representative of PMC may discuss my protected health information

✓ **Date of service or period of time that you wish us to disclose**_____

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services; and/or treatment for alcohol and drug abuse, which is protected by virtue of the provisions of Federal Regulations 42 CFR, part 2.

✓ **This information may be disclosed to and used by the following individual or organization:**

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

✓ **This information is needed for the purpose of:** _____

I understand that I have the 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 Medical Record Department. I understand that the authorization is subject to revocation at any time except to the extent that the program or person, which is to make the disclosure, has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer. Additional information regarding the individual's right to revoke an authorization is found in PMC's notice of privacy practices.

✓ **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:**_____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524.

I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules (unless the information is protected by 42 CFR for alcohol/drug abuse records).

If I have questions about disclosure of my health information, I can contact the Pioneer Medical Center Medical Record Department.

_____ _____

✓ **Signature of Patient or Legal Representative** **Date**

_____ _____

If Signed by Legal Representative (Relationship to Patient) **Witness**