PIONEER MEDICAL CENTER
P.O.Box.1228, Big Timber, MT 59011
406-932-4603 Fax: 406-932-4484

Authorization to Disclose Protected Health Information

Patient Name: _____ Date of Birth: _____/_____/_____

Phone: (_____) _____Cell Phone: (_____) _____

Address: _____City:_____State:_____Zip:_____

Office/Physician that will *provide* this health information:

Name: _____ Address: _____

Fax: _____Telelphone:_____

I request my protected health information (PHI) to be released from my medical record(s) & please check all that apply or describe the information specifically:

☐Hospital Medical Records ☐Clinic Medical Records ☐X-Ray Reports ☐Radiology Disc ☐Pathology Reports

☐Immunization Records ☐Billing Records ☐Outpatient Records

☐Specific Date(s):_____to _____ or **if no dates are specified, the last two (2) years will be released**.

☐Other: _____

I authorize the release of information in my health record which may include:

☐Behavioral or Mental Health Issues
☐Psychiatric Records
☐Sexual Transmitted Diseases
☐Sexual Assault Nurse Examiner Reports
☐Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)
☐Alcohol and Drug Treatment

Health Information is to be *sent* to:

Name: _____ Address: _____

Fax: _____Telelphone:_____ _____

Purpose for requesting information:

☐Request of Patient ☐Continuation of Care ☐Other:_____

Unless otherwise revoked, this authorization will expire on the following date.

☐ 3 month ☐ 6 months; **if you do not indicate an expiration date, this authorization to release expires six (6) months after it is signed.** If you wish for this authorization to expire when an event occurs, please describe the event in detail (i.e. when the records have been sent).☐ Event: _____

_____

By signing this authorization, I understand that:

- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to the Pioneer Medical Center Health Information Management Department. I understand that I cannot revoke authorization for information that has already been released in response to this authorization. Additional information regarding the individual's right to revoke an authorization is found in Pioneer Medical Center's Notice of Privacy Practices.
- I understand that this authorization is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive treatment, payment for services, enrollment or eligibility for benefits. I understand that I may inspect or copy this authorization as provided in §45 CFR 164.524.
- I understand that any disclosure of information under this authorization carries with it the potential for an unauthorized re-disclosure by the recipient and, after it is disclosed, the information may not be protected by state or federal confidentiality rules.
- If I have questions about disclosure of my health information, I can contact Pioneer Medical Center Health Information Management Department.

Patient/**Authorized Representative*** ****Signature: _____

Date: _____Time: _____

Printed Name of Authorized Representative: _____

Relationship to the Patient: _____

*****When signed by a patient's authorized representative, supporting legal documentation must accompany this authorization form.**