Pioneer Medical Center
301 W 7th Ave
Big Timber, MT 59011
P: (406) 932-4603
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Standard Authorization to Use or Disclose Protected Health Information

Section A: I give my permission to release health information for the individual listed below. Read the following information to be sure that it is correct:

Name: _____ Date of Birth: _____

Telephone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Section B: Office/Physician that will provide this health information:

Name: _____

Address: _____

_____

Fax: _____ Telephone: _____

Section C: This information is to be sent to:

Name: _____

Address: _____

_____

Fax: _____ Telephone: _____

Section D: Describe the specific Protected Health Information to use or disclose, including date(s):

MUST BE COMPLETED BEFORE RECORDS RELEASED

☐ Complete Medical Record (this would include Psychiatric (mental health) information, HIV and/or AIDS related diagnosis, evaluation information, and Substance Abuse (Drug or Alcohol) information)

☐ Partial Medical Record – Do not include the following areas of my records in this release:

- ☐ Psychiatric (mental health) information
- ☐ HIV and/or AIDS related diagnosis, evaluation information
- ☐ Substance Abuse (Drug or Alcohol) information

☐ Specific Medical Records (e.g. clinic notes, ER notes, hospital visits, etc.): _____

For: ☐ Last two years OR the following dates of service: _____

Describe the reason for the release or request of information: ☐ At the request of individual ☐ Continuation of Care or Other: _____

Section E: I understand that:

- This authorization is voluntary. I am not required to sign this form. Pioneer Medical Center (PMC) does not condition treatment, payment benefit eligibility, or enrollment activities on the signing of this form. If I do not sign this form, PMC will not disclose my health information as requested.
- I may revoke this authorization at any time by notifying in writing the company/individual listed in Section B from providing the PHI identified in this authorization, but if I do revoke this authorization, it won't have any effect on any PMC actions before they received the revocation.
- Once my health information is disclosed as requested in this authorization my health information may no longer be protected by federal and state privacy laws and potentially ay be re-disclosed
- Information used as a result of this authorization may not be further disclosed by PMC without the written authorization of the person to whom it pertains
- I may receive a copy.

Section F: Signature

I hereby authorize the use or disclosure of the Protected Health Information as described in Section D for the individual listed in Section A. This authorization will expire in one year.

Signature of Individual or Personal Representative: _____ **Date:** _____

Section G: If Section F is signed by a Personal Representative, please complete the information below:

Personal Representative's Name: _____

Relationship to Individual: _____

Personal Representative's Address: _____ City: _____ State: _____ Zip: _____

Personal Representative's Area Code and Telephone Number: _____