Pioneer Medical Center
PO Box 1228 Big Timber, MT 59011
PH: 406.932.4603 Med Rec Fax: 406.932.4484

Authorization to Release Protected Health Information

Patient Legal Name:_____ Date of Birth:_____
Please Print

Released From:	Released To:
Healthcare Facility:_____	Facility/Name:_____
Address:_____	Address:_____
City, State, Zip: _____	City, State, Zip: _____
Ph#: _____Fx#:_____	Ph#: _____Fx#:_____

Records to be released

☐ Hospital Reports ☐ Rad Reports ☐ Rehab Reports ☐ Entire Record
☐ Clinic Reports ☐ Image Disc ☐ Immunizations ☐ Billing Statements
☐ Lab Reports ☐ Other:_____

Additional Specifications:_____
Date(s): _____to_____ **If no dates are specified, the last 2yrs will be released.**

Special Authorizations: I authorize the release of sensitive information to be included. Any boxes not checked will not be released. This authorization does not apply to psychotherapy notes.

☐ Behavioral/Mental Health ☐ Sexual Transmitted Diseases ☐ HIV/AIDS
☐ Psychiatric Records ☐ Sexual Assault Exam ☐ Substance Abuse/Treatment

Purpose of Disclosure ☐ Patient Use ☐ Continuing Care ☐ Other:

By signing this authorization, I understand that:

- This authorization is voluntary. I can refuse to sign this authorization. My signature is not conditional to receive treatment, payment for services, enrollment or eligibility for benefits as provided for in §45 CFR 164.524.
- 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 I cannot revoke authorization for information already released in response to this authorization.
- I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and the information may not be protected by state or federal confidentiality rules.
- Fees may be charged for the request to disclose information in accordance with Federal and State laws.
- I have the right to a copy of this authorization. I can request a copy of Pioneer Medical Center's Notice of Privacy Practices for additional information regarding disclosure of my health information and my right to revoke an authorization. If I have any questions, I can contact PMC's Health Information Management Department.

Signature:_____ Date:_____ Time:_____
Patient/Authorized Representative

Printed Name_____ Relation (if not patient):_____
If signed by a patient's legal representative, supporting legal documentation must accompany this authorization form

This authorization will expire: ☐ 3 months ☐ 6 months ☐ Specific Date:_____

If no expiration date is indicated, this authorization will expire one (1) year from date of signature, unless otherwise revoked.

PMC Use Only Date:	Delivery Method:	# of pages:	PMC Initials:

I hereby revoke/cancel this Authorization to Release Protected Health Information

Cancellation Signature:_____ Date:_____ Time:_____