NORTHERN MONTANA HEALTH CARE

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Portal – Proxy Access

NAME OF PATIENT:_____ BD:_____MRN:_____

DATES OF SERVICE: Any and all

I HEREBY AUTHORIZE: Northern Montana Health Care

TO DISCLOSE THE BELOW INFORMATION TO:_____

_____

INFORMATION TO BE DISCLOSED:

****I understand that this may include information relating to alcohol and/or drug abuse, behavioral health and/or other highly confidential information obtained during the course of my diagnosis and treatment.****

___Complete medical record(s) ----or specifically those parts checked below:

____Discharge Summary	___Pathology Report	___Emergency Room Notes
___History and Physical Exam	___Progress Notes	___Immunization Records
___Consultation Reports	___Laboratory Tests	___TB (PPD) Screening Results
___Operative Note	___X-ray/Imaging Reports	

___Accounting of Disclosures

___Billing information

___Photographs, videotapes, digital or other images

_X_Patient Portal Access: Proxy email (required):_____

___Psychotherapy Notes

___Other (please specify):_____

PURPOSE OF DISCLOSURE: Personal – Access to health information on patient portal

If minor – at age of majority

EXPIRATION DATE OR EVENT: If adult – until such time it is revoked by me

(Expires in 6 months if not specified)

****I understand that this authorization may be revoked in writing at any time to the HIM Department, except for disclosures already made in response to this authorization.****

****I understand that treatment, payment, enrollment or eligibility benefits may not be affected by me signing this authorization unless allowed by the Federal Privacy Laws.****

****I understand that if this information is redisclosed by the recipient, it may no longer be protected by the Federal Privacy Laws.****

_____ _____

Signature of patient **OR** personal representative and (description of authority) Date

_____ _____

Proxy Signature Date