

NORTHERN MONTANA HEALTH CARE

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

NAME OF PATIENT: _____ BD: _____ MRN: _____

DATES OF SERVICE: _____

I HEREBY AUTHORIZE: _____

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 | ___ Office Visit Notes |

___ Accounting of Disclosures

___ Billing information

___ Photographs, videotapes, digital or other images

___ Psychotherapy Notes

___ Other (please specify): _____

PURPOSE OF DISCLOSURE: _____

EXPIRATION DATE OR EVENT: _____

(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 re-disclosed 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

Witness

Date

ADM 0702e 09/16

