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

___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