NORTHERN MONTANA HEALTH CARE

AUTHORIZATION FOR DISCLOSURE OF PHI - PORTAL

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	___Office Visit Notes

___Accounting of Disclosures

___Billing information

___Photographs, videotapes, digital or other images

_X_ Patient Portal Access: Proxy email (required): _____

___Other (please specify): _____

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

EXPIRATION DATE OR EVENT: If minor – at age of majority
If adult – until such time 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/Parent or Legal Guardian Date

** If applicable: must attach copy of legal paperwork to verify authority.*

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Relationship to patient