NORTHERN MONTANA HEALTH CARE

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

NAME OF PATIENT:_____DOB:_____

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	☐ Billing information
☐History and Physical Exam	☐Progress Notes	☐Immunization Records	☐ Photographs, video, or other images
☐Consultation Reports	☐Laboratory Tests	☐TB (PPD) Screening Results	☐ Accounting of Disclosures
☐Operative Note	☐Imaging Reports	☐Office Visit Notes	☐Other:_____

☐ Patient Portal Access: Proxy email(required) _____

METHOD TO RECEIVE PHI:

☐Email: _____
☐Mailed: (address)_____
☐Faxed: (number)_____
☐Send to third party (name/address/fax)_____

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

ROI

HIM USE ONLY:

MRN:_____ DATE SENT:_____

Initials of HIM employee: _____