RECORDS RELEASE

Madison Valley Medical Center

305 N Main Street, Ennis, Montana 59729 Phone
406-682-6862 Fax 406-682-4756

Authorization for Release of Patient-Identifiable Health Information

Patient Name: _____ Date of Birth: _____
Patient Record Number: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. **From:** The following individual or 3. **To:** This information may be disclosed to and organization is authorized to make the disclosure: used by the following individual or organization:

_____ _____
_____ _____
_____ _____ 4. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

☐ Medication list
☐ History and physical
☐ Laboratory results
From (date) _____to_____
☐ Consultation reports
From (Dr's Name) _____
☐ Immunization record
☐ Discharge summary
☐ X-rays reports films
From (date)_____to_____
☐ Entire record
Clinic Hospital
☐ Other_____
_____

5. I understand the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I do not wish this information to be released. _____ Date _____

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records Department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company where the law provides my insurer the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six (6) months, according to Montana Law. I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Madison Valley Medical Center privacy officer.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to patient, or reason for signing Signature of Witness

YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT