COMMUNITY MEDICAL CENTER

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH CARE INFORMATION

I hereby authorize **COMMUNITY MEDICAL CENTER** 2827 Fort Missoula Road, Missoula, MT 59804 (406) 728-4100 to release information from the medical records of: Phone # _____

_____

Patient's Name (please print) **Date of Birth** **SSN#**

To: _____

Party to receive information **Address**

This information for which I'm authorizing disclosure will be used for the following purpose:

☐ **My personal records**

☐ **Sharing with other health care providers as needed**

☐ **Other (please describe):_____**

The type of information to be used or disclosed is as follow (check the appropriate boxes and include other information where indicated):

☑	**Type of Information Requested:**		**Lab Results** – specify date(s) or type of labs to be disclosed:
	Discharge Summary		
	X-ray Report		**Consultation Report from Dr.**
	Immunization Records		
	History and Physical		**Entire Record**
	EKG		
	ER Record		**Other:** (please describe)
	Specified Date(s) of service if known:		

I understand that the records released may contain the following information, which is protected by state and/or federal law, and authorize you to release this information (*you must initial all those that apply*):

_____*Mental Health Treatment
_____*Drug and Alcohol Abuse
_____*Aids/HIV related information

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless I specify differently, this authorization will expire (insert date or event)_____. If I fail to specify an expiration date or event, this authorization will expire in six months from the date on which it was signed. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal or state privacy laws or regulations. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. *I acknowledge that I may be charged a reasonable, cost-based fee for making copies. I acknowledge that third-party payers and other parties requesting health information on behalf of myself with my authorization will be charged as state laws allow.*

Signature of patient or legal representative **Date**

Relationship to Patient

Community Medical Center, 2827 Fort Missoula Road, Missoula Montana 59804
Health Information Management Department
Phone: 406-327-4085
Fax: 406-327-4510

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