AUTHORIZATION FOR DISCLOSURE OF HEALTH CARE INFORMATION

Allergy & Asthma Center, PC
20 Four Mile Dr. #2
Kalispell, MT 59901

Phone: (406) 300-4882
Fax: (406) 257-2706

I, _____ AUTHORIZE THE RELEASE OF _____ RECORDS
(PATIENT, PARENT, LEGAL GUARDIAN) (PATIENT NAME)

BIRTH DATE ____/____/____ SS# ____-____-____ PHONE # (___) ___-_____

RECORDS FROM:

PERSON/FACILITY PHONE#, FAX#

STREET ADDRESS CITY, STATE, ZIP

TO RELEASE TO:

PERSON/FACILITY PHONE #, FAX #

STREET ADDRESS CITY, STATE, ZIP

THE FOLLOWING HEALTH CARE INFORMATION:

____DISCHARGE SUMMARY/HISTORY & PHYSICAL
____EMERGENCY ROOM REPORT
____OPERATIVE/PATHOLOGY
____OTHER (PLEASE SPECIFY)_____
____RADIOLOGY/LABORATORY REPORTS
____PROGRESS NOTES
____REPORTS

FOR THE PURPOSE OF:

THIS CONSENT RELEASES INFORMATION PERTAINING TO: ***MUST CHECK BOX & INITIAL***

____[ ] INCLUDES ____[ ]EXCLUDES DRUG/ALCOHOL ABUSE DIAGNOSIS OR TREATMENT
____[ ] INCLUDES ____[ ]EXCLUDES POSITVE HIV (AIDS) TREATMENT OR TESTING
____[ ] INCLUDES ____[ ]EXCLUDES PSYCHOLOGICAL OR PSYCHIATRIC INFORMATION
____[ ] INCLUDES ____[ ]EXCLUDES INFORMATION ON SEXUALLY TRANSMITTED DISEASES

I understand that the health care information released pursuant to this Authorization includes oral communications as well as information recorded in any medium including, but not limited to, information recorded on handwritten, typed or computer-generated records. This includes film, audiotapes, videotapes and computer discs.

I understand that necessary health care information can be exchanged to the extent necessary to provide health care to the patient unless specific written instruction to the contrary has been received (50-16-529 MCA).

I understand that records are protected under confidentiality regulations, and any records that contain information regarding drug/alcohol abuse that are created by an alcohol abuse or drug abuse prevention program are protected under federal confidentiality laws (42 CFR Part 2). I understand that said records containing information about the diagnosis, treatment, or referral of alcohol and drug abuse problems cannot be disclosed without my written consent, and that those receiving this information are prohibited from redisclosing these records unless expressly permitted by my written consent. I understand that HIV test or treatment records cannot be disclosed without my written consent unless permitted by State Law, and that those receiving this information are prohibited from redisclosing these records without my further written consent. I may revoke this consent at any time unless action has been taken in reliance on it.

THIS CONSENT WILL EXPIRE IN 6 MONTHS

Signature Witness/Relationship

Date Date