

AUTHORIZATION FOR DISCLOSURE OF HEALTH CARE INFORMATION

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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 _____ RADIOLOGY/LABORATORY REPORTS
____ EMERGENCY ROOM REPORT _____ PROGRESS NOTES
____ OPERATIVE/PATHOLOGY _____ REPORTS
____ OTHER (PLEASE SPECIFY) _____

FOR THE PURPOSE OF:

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

____ INCLUDES _____ EXCLUDES DRUG/ALCOHOL ABUSE DIAGNOSIS OR TREATMENT
____ INCLUDES _____ EXCLUDES POSITIVE 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