

AUTHORIZATION FOR RELEASE OF INFORMATION

*****IMPORTANT: In order for authorization to be valid ALL areas must be completed*****

Patient Last Name **First Name** **MI** **Date of Birth** **Social Security Number**

Patient Address (PO Box/Street) **City** **State** **Zip** **Daytime Telephone Number**

I AUTHORIZE THE FACILITY BELOW TO RELEASE MY PROTECTED HEALTH INFORMATION: <input type="checkbox"/> Missoula Surgical Associates <input type="checkbox"/> Western Montana Clinic Other: _____ _____	Outside Facility: (Complete this section <u>ONLY</u> if you are requesting to have records sent to one of the facilities on the left). _____
	Healthcare Provider Name _____
	_____ City/State/Zip _____
	Address _____ Telephone/Fax Number _____

Information to be Released

All medical records
 Only medical records from _____ (Specific health care provider)
 Only dates of service from _____ to _____
 Information from medical record for the completion of a disability form
 Other _____

Send the Information to: _____

Address: PO Box/Street _____

City _____ **State** _____ **Zip** _____

Fax Information: YES NO **Fax Number:** _____ (maximum of 15 pages)

Reason for Request: Legal Moving Review Own Records Insurance Claim Dissatisfaction Changing Physician
 Other _____

The medical record includes all health care information, whether oral or recorded in any form or medium that identifies the patient or can readily be associated with the patient and relates to the patient's care. This includes all health care information in your/our possession, whether generated by you/us or any other source, as well as health care information associated with drug/alcohol abuse, mental or psychiatric care, abortion, and HIV status and/or diagnosis of AIDS and/or other sexually transmitted diseases including hepatitis.

The following WILL NOT be released unless you indicate your specific authorization by initialing each appropriate category:

Drug/Alcohol Abuse Aids/HIV Related Information Sexually Transmitted Disease Behavioral or Mental Health Issues

If one of the above facilities is requesting this authorization be completed, an individual has the right not to sign with the understanding that an individual's health care and the payment for health care will not be affected.

I understand that this authorization may be revoked by me at any time, provided that I do so in writing and submit it to the Medical Records Department, up to the extent that the disclosure has not already been made. I also understand that my protected health information may be re-disclosed by the recipient and no longer be protected under federal law. Authorization will expire in 6 months unless otherwise specified below.

Patient Signature (if over 18) **Date** **Expiration Date**
 OR

Legal Representative/Guardian **Date** **Relationship to Patient**

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Form- PF 6 Revised 6/9/2015