KALISPELL REGIONAL HEALTHCARE

Authorization to Disclose Protected Health Information

Patient Information

Name: _____ Date of Birth: _____

Address: _____ Day Phone: _____

City: _____ State: _____ Zip: _____

Hospital/Clinic/Health Care Provider
(Who has the information you want released? Please list the specific hospital and/or clinic.)

Facility Name: _____ Phone: _____ Fax: _____

Facility Name: _____ Phone: _____ Fax: _____

Facility Name: _____ Phone: _____ Fax: _____

Receiving Party
(Where do you want the information sent? Who may have the information?)

Name: _____

Address: _____ Day Phone: _____

City: _____ State: _____ Zip: _____

Fax Number: _____

Information to be Released
(What do you want sent or released? Check the appropriate box.)

Date range of information to be released: From: _____ (Month/Year) To: _____ (Month/Year)

Please check specific information to be released:

- ☐ Entire Record
- ☐ Discharge Summary/Note
- ☐ History and Physical
- ☐ Consultation Report
- ☐ Operative Report
- ☐ Progress Notes
- ☐ Emergency Record(s)
- ☐ Pathology Reports
- ☐ Laboratory Reports
- ☐ Medication List
- ☐ CT ☐ reports ☐films/CD
- ☐ MRI ☐ reports ☐films/CD
- ☐ Mammogram ☐ reports ☐films/CD
- ☐ Ultrasound ☐ reports ☐films/CD
- ☐ X-ray ☐ reports ☐films/CD
- ☐ Billing
- ☐ Other _____

Release Instructions
(How and when do you want the information?)

Date information is needed: _____

Disclosure Method: ☐ Pickup ☐ Mail ☐ CD ☐ Fax # _____

Email Address _____

Note: Records that are e-mailed will be sent through KRH Secure e-mail server.

☐ Other _____

Note: *Fees may be charged in accordance with Federal and State law.

By signing this authorization form, I understand that:

- The information in the health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) and genetic information. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- This authorization does not apply to psychotherapy notes.
- Once the information described herein is disclosed, it could be redisclosed by the recipient and may not be protected by privacy protections.
- I have the right to revoke this Authorization at any time. Revocation must be in writing and presented to Health Information Management (fax 756-3523). Revocation will not apply to information that has already been disclosed in response to this Authorization.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Requests for copies of health records are subject to reproduction fees in accordance with Federal and State law.
- I will receive a copy of this Authorization.
- Unless otherwise revoked, this Authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this Authorization will expire six (6) months from the date it is signed.

_____ Signature of Patient or Legal Representative

_____ Printed Name

_____ Date

_____ If Signed by Legal Representative, Relationship to Patient

_____ Signature of Witness

_____ Printed Name

For Office Use Only:
Signature/ID verified ☐ Yes ☐ No
MRN/Log #: _____

Completed by _____ Name/Date

# of pages released _____

Revocation Authorization

I hereby revoke (cancel) this Authorization to Disclose Protected Health Information.

Cancellation Signature: _____ *Date:* _____