KALISPELL REGIONAL HEALTHCARE

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Date: _____ MD:_____ Authorization #:_____

Patient Name:_____

Date of Birth:_____ SSN:_____

Information to be released from: _____

_____

_____

This information may be disclosed to and used by the following individual or organization: (Use additional forms if more than one recipient.)

Information to be used for the purpose of:
☐ Requested by Patient ☐ Other_____

I hereby request and authorize you to disclose information to:

Name	Polson Health 102 13th Avenue East Polson, MT 59860 Phone (406) 883-3200 | Fax (406) 883-9483

Disclosure Method
☐ Pickup ☐ Mail
☐ Fax #_____
Other_____

I authorize the disclosure and use of the above named patient's health information as described below.
Information to be released:

☐ All Records of Treatment from (date) _____ to _____(date)

☐ Entire (Complete Record)	☐ Immunization Record	☐ Allergy List	☐ Ultrasound ☐ reports or ☐films/CD
☐ History & Physical Report	☐ Medication Record	☐ CT ☐ reports or ☐films/CD	☐ Xray ☐ reports or ☐films/CD
☐ Consultation Report	☐ Progress Notes	☐ MRI ☐ reports or ☐films/CD	☐ Other _____
☐ Operative Report	☐ Lab Results	☐ Mammogram ☐ reports or ☐films/CD	☐ Other _____

- 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, marketing or drug and alcohol treatment records.
- I understand that once the information described herein is disclosed, it could be redisclosed by the recipient and no longer subject to the privacy protections.
- Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____. If I fail to specify an expiration date, event or condition, this authorization will expire.
- I understand that this authorization may be revoked in writing at any time by fax to Health Information Management at 756-3523.
- I understand that this revocation does not apply to information that has already been released in response to this authorization.
- I understand that this authorization must be signed by the patient or other legal representative in order to receive my records.
- I understand that a charge may be made for copies of the records in accordance with Montana State Law ($15.00 administrative fee and .50 per photocopy page).

_____ _____

Signature of Patient or Legal Representative Printed Name Date

_____ _____

If signed by Legal Representative, Relationship to Patient Signature of Witness Printed Name Date

For Office Use Only: Copied by:	☐ Check ID Type:_____ Date Copied:	Amount Received:

- I revoke (cancel) this Authorization to Disclose Health Information previously signed on _____ (date).

Cancellation Signature:_____ Date: _____