Glendive Medical Center

Health Information Management- Release of Information
202 Prospect Dr., Glendive, MT 59330
(406) 345-3390 Hospital Fax (406) 345-3392 Clinic Fax (406) 345-8908

Authorization to Disclose Health Care Information

Patient Name: _____ Date of Birth: _____/_____/_____

Phone: (_____) _____ Cell Phone: (_____) _____

I request my protected health information (PHI) from: (please check all that apply)-

☐ Gabert Clinic ☐ Glendive Medical Center ☐ Request for records to be sent to Glendive Medical Center

I request my protected health information (PHI) to be: used or disclosed to following person, class of persons, or organization: ☐ release of medical records ☐ verbal discussion ☐ No records sent at this time please keep

☐ Release to: ☐ Request from:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____

I request my protected health information (PHI) to be released from my medical record(s): (Please check all that apply or describe the information specifically):

☐ Hospital Medical Records ☐ Clinic Medical Records ☐ Immunization Records ☐ Pathology Reports
☐ Radiology Reports ☐ Psychiatric Records ☐ Billing Records ☐ Laboratory Results
☐ Radiology Images
☐ Specific Date(s):_____ to _____ **or if no dates are specified, the last two (2) years will be released**
☐ Provider's Name: _____
☐ Other_____
_____

I authorize the release of information in my health record which may include information related to:

☐ Behavioral or Mental Health Issues ☐ Sexually Transmitted Diseases ☐ Sexual Assault Nurse Examiner Reports
☐ Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)
☐ Alcohol and Drug Treatment

Purpose for requesting information: (Please check one)

☐ Request of Patient ☐ Continuation of Care ☐ Other: _____

Unless otherwise revoked, this authorization will expire on the following date. If you do not indicate an expiration date, it expires six months after it is signed. If you wish for this authorization to expire when an event occurs, please describe the event in detail (i.e. when the records have been sent).

☐ 3 months ☐ 6 months ☐ Event_____

By signing this authorization, I understand that:

- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to the Glendive Medical Center Health Information Management Department. I understand that I cannot revoke authorization for information that has already been released in response to this authorization. Additional information regarding the individual's right to revoke an authorization is found in Glendive Medical Center's Notice of Privacy Practices.
- I understand that this authorization is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive treatment, payment for services, enrollment or eligibility for benefits. I understand that I may inspect or copy this authorization as provided in 45 CFR 164.524.
- I understand that any disclosure of information under this authorization carries with it the potential for an unauthorized re-disclosure by the recipient and, after it is disclosed, the information may not be protected by state or federal confidentiality rules.
- If I have questions about disclosure of my health information, I can contact Glendive Medical Center Health Information Management Department.

Patient/Authorized Representative* Signature:_____ Date:_____ Time:_____

Printed Name of Authorized Representative:_____ Relationship to Patient:_____

*If signed by a patient's authorized representative, supporting legal documentation must accompany this authorization form.