



AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Date: _____

Authorization #: _____

Patient Name: _____

Date of Birth: _____ SSN _____

Information to be released from: **Kalispell Regional Medical Center**
310 Sunnyview Lane
Kalispell, MT 59901

This information may be given to and used by the following individual or organization:

Information to be used for the purpose of: <input type="checkbox"/> Requested by Patient <input type="checkbox"/> Other
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I hereby request and authorize you to release information to:

Name _____ Address _____ _____ _____

Disclosure Method <input type="checkbox"/> Pickup <input type="checkbox"/> Mail <input type="checkbox"/> Fax # _____ Other _____ _____
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I authorize the use or disclosure of the above named individual's health information as described below.

Information to be released:

- | | | |
|---|---|---|
| <input type="checkbox"/> All Records of Treatment from _____ to _____ | <input type="checkbox"/> Medication Record | <input type="checkbox"/> Allergy List |
| <input type="checkbox"/> Entire (Complete Record) | <input type="checkbox"/> Physician's Orders | <input type="checkbox"/> X-ray Reports |
| <input type="checkbox"/> History & Physical Report | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Drug/Alcohol Information |
| <input type="checkbox"/> Consultation Report | <input type="checkbox"/> Lab Results | <input type="checkbox"/> Psychiatry Information |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> HIV Results | <input type="checkbox"/> Other |
| <input type="checkbox"/> Immunization Record | | |

- I understand that the information in my health record may include information relating to sexually transmitted disease, behavioral or mental health services, and treatment for alcohol and drug abuse.
- I understand there will be a charge for copying records.
- I understand that if the person or entity that receives the information is not a health care provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in the federal privacy regulations.
- 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 in six months.
- I understand that I may revoke this authorization in writing at any time by contacting the Privacy Officer at (phone number) _____
- I understand that this revocation does not apply to information that has already been released in response to this authorization.
- Failure to sign this authorization
 - Will have no adverse impact on delivery of care or reimbursement of patient charges
 - Will have the following adverse impact: _____

Signature of Patient or Legal Representative _____

Date _____

If signed by Legal Representative, Relationship to Patient _____

Signature of Witness _____

For Office Use Only: Copied by: _____	<input type="checkbox"/> Check ID Type: _____ Date Copied: _____	Amount Received: _____
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- I revoke (cancel) this Authorization to Disclose Health Information previously signed on _____ (date).

Cancellation Signature: _____

Date: _____