Roundup Memorial Healthcare
Health Information Management – Release of Information
P.O. Box 40
Roundup, MT 59072
(406) 323-2301 FAX (406) 323-4924

Authorization to Disclose Health Care Information

Patient Name:____ **Date of Birth:_____/____/_______**

Phone: (____) _____________________ **Cell Phone: (____) _____________________**

I request my protected health information (PHI) from:

Name:____ PH: _________________________ FAX:______________________
Address:____
City:________________________________ State:________________ Zip:_____________________________________

I request my protected health information (PHI) be released to:

Name:____ PH:_________________________ FAX:____________________
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 ☐ Lab / Pathology Reports
☐ X-Ray Reports ☐ Radiology Disc ☐ Billing Records
☐ Specific Date(s):_______________to_______________ ☐ 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
☐ 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:_________________________**

You may revoke this authorization at any time by providing a written revocation. 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. never, when the records have been sent).

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 Roundup Memorial Healthcare 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 Roundup Memorial Healthcare's Notice of Privacy Policy.
- 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 Roundup Memorial Healthcare 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 form.