



Note: Federal law requires ALL information be completed before information can be released

**AUTHORIZATION TO DISCLOSE
PRIVATE HEALTH CARE INFORMATION**

NAME OF PATIENT: _____ **DOB:** _____

Phone Number: _____

MEDICAL RECORDS FROM

I authorize the following facility to release my protected health information (PHI):

Beartooth Billings Clinic

OR

Other Organization or Individual

2525 North Broadway
PO Box 590
Red Lodge, MT 59068
Phone: 406-446-2345
Fax: 406-446-0095

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____
Fax: _____

MEDICAL RECORDS TO

I authorize the following facility to receive my protected health information (PHI):

Release to Beartooth Billings Clinic

Attention Provider(s):

2525 North Broadway Phone: 406-446-2345
PO Box 590 Fax: 406-446-0095
Red Lodge, MT 59068

- Dr. Jose Ortiz
- Doug Whitehead PA-C
- Dr. Greg Burfeind
- Hailey Baldwin PA-C
- Dr. Dallas Clark
- Erin Oley DNP, FNP
- Other: _____

Release of PHI to: **OR** **Verbal discussion with:**

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
Email (only if method of delivery) : _____

No PHI at this time, please keep on file



Please check all that apply:	<input type="checkbox"/> Hospital Medical Records	<input type="checkbox"/> Lab Reports	<input type="checkbox"/> Billing Records
	<input type="checkbox"/> Clinic Medical Records	<input type="checkbox"/> X-ray Reports	<input type="checkbox"/> All Medical Records (May not include sensitive data unless specified below)
	<input type="checkbox"/> Rehab Records	<input type="checkbox"/> X-ray Images (Completed by BC)	<input type="checkbox"/> Other, Please Specify:
	<input type="checkbox"/> Immunization Records	<input type="checkbox"/> Pathology Reports	
	<input type="checkbox"/>	<input type="checkbox"/>	
I authorize the release of information in my health record which may include information related to:	<input type="checkbox"/> Sexually transmitted disease <input type="checkbox"/> Behavioral or mental health services <input type="checkbox"/> Treatment for alcohol and drug abuse which is protected by virtue of the provision of Federal, part 2 <input type="checkbox"/> Acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV) <input type="checkbox"/> Not Applicable or I do not authorize above to be released		
Time Period of Requested Information:	<input type="checkbox"/> Specific Date(s): _____ to _____		
This information is needed for the purpose of:	<input type="checkbox"/> Continuation of Care <input type="checkbox"/> At the request of the patient <input type="checkbox"/> Other: _____		
<p>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).</p>			
<input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 1 year	<input type="checkbox"/> Maximum limit (30 months) <input type="checkbox"/> Other: _____ <input type="checkbox"/> Event (Please describe): _____		
<u>By signing this authorization, I understand that:</u>			
<p>1. I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to the Beartooth Billings Clinic 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 Beartooth Billings Clinic's Notice of Privacy Practices.</p>			
<p>2. I understand that authorizing the disclosure of this health information 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 from Beartooth Billings Clinic. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524.</p>			
<p>3. I understand that any disclosure of information 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.</p>			
<p>*I understand there may be a fee associated with this disclosure and the normal turn-around time for disclosing records is 7-10 business days*</p>			
<p>If I have questions about disclosure of my health information, I can contact the Beartooth Billings Clinic Health Information Department at 406-446-2345.</p>			
Signature of Patient or Authorized Representative*			
Printed Name of Patient or Authorized Representative & Relationship to Patient			
Date			

*Supporting legal documentation must accompany this authorization form if being completed by Authorized Representative