Beartooth Billings Clinic

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

2525 North Broadway
PO Box 590
Red Lodge, MT 59068

Phone: 406-446-2345
Fax: 406-446-0095

OR

❒ Other Organization or Individual

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

2525 North Broadway
PO Box 590
Red Lodge, MT 59068

Phone: 406-446-2345
Fax: 406-446-0095

Attention Provider(s):

❒ Dr. Jose Ortiz
❒ Dr. Greg Burfeind
❒ Dr. Dallas Clark
❒ Anna Nesovic, DNP
❒ Hailey Baldwin, PA-C
❒ Erin Oley DNP, FNP
❒ Dr. William Oley
❒ Danielle Sankey, ANP
❒ 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

Beartooth Billings Clinic

Please check all that apply:	❒ Hospital Medical Records	❒ Lab Reports	❒ Billing Records
	❒ Clinic Medical Records	❒ X-ray Reports	❒ All Medical Records *(May not include sensitive data unless specified below)*
	❒ Rehab Records	❒ X-ray Images (Completed by BC)	❒ Other, Please Specify:
	❒ Immunization Records	❒ Pathology Reports	

I authorize the release of information in my health record which may include information related to:	❒ Sexually transmitted disease ❒ Behavioral or mental health services ❒ Treatment for alcohol and drug abuse which is protected by virtue of the provision of Federal, part 2 ❒ Acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV) ❒ **Not Applicable or I do not authorize above to be released**
Time Period of Requested Information:	❒ Specific Date(s): _____ to _____
This information is needed for the purpose of:	❒ Continuation of Care ❒ At the request of the patient ❒ 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 ❒ 1 year	❒ Maximum limit (30 months) ❒ Other:_____ ❒ Event (Please describe):_____

By signing this authorization, I understand that:

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.

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.

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.

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

If I have questions about disclosure of my health information, I can contact the Beartooth Billings Clinic Health Information Department at 406-446-2345.

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