Beartooth Billings Clinic

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Failure to provide all information may invalidate this authorization.

Patient Name: _____

Date of Birth: _____ Patient Phone: _____

Purpose of Request:

☐Personal Records ☐Transition of Care ☐Insurance ☐Other _____

I authorize information to be released FROM:

☐Beartooth Billings Clinic
PO Box 590; 2525 North Broadway
Red Lodge, MT 59068

☐Facility Name: _____
Address: _____
_____
Phone/Fax _____

Individual/Agency/Facility I would like information to be SENT to:

☐Facility/Person: _____
Address _____
_____
Phone/Fax _____
Email: _____
Provider Name: _____

☐Beartooth Billings Clinic
PO Box 590; 2525 North Broadway
Red Lodge, MT 59068
P: (406) 446-2345 F: (406) 446-0095
Email: Medicalrecords@beartoothbillingsclinic.org
Provider Name: _____

Types of information to be released:

☐Clinic Records ☐Lab & Pathology ☐Rehab Records
☐Hospital Records ☐Radiology Reports ☐Home Care & Hospice
☐Emergency Room Reports ☐Radiology Images (CD) ☐Billing Records
☐Immunization Records ☐Operative Reports ☐All Records (past 2 years)
☐Other (Please Specify) _____

Dates of Service _____

Format Requested ☐Verbal Discussion ☐Email (Limited by Size) ☐Fax ☐Disc ☐Mailed ☐In Person Pick Up

Re-Disclosure and Right to Revoke:

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I may revoke this authorization at any time by presenting a written revocation to the Medical Records Department. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. I understand the revocation will not apply to information that has already been released in response to this authorization. Additional information regarding the individual's right to revoke an authorization can be found in Beartooth Billings Clinic's Notice of Privacy Practices. ***Unless revoked, this authorization will expire in*** **☐6 months ☐ 1 year ☐ 2 years**

Sensitive Information:

If the information to be disclosed contains any of the types of information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed by checking the applicable space next to the type of information.

☐HIV/AIDS Information ☐Genetic Testing Information ☐Sexual Assault Information
☐Mental Health Information ☐Drug/Alcohol Diagnosis ☐Sexually Transmitted Disease

Signature of Patient or Personal Representative Requesting Disclosure:

I understand that authorizing the disclosure of this health information is voluntary. I understand I can refuse to sign this authorization. I understand I do not need to sign this form to receive treatment, for payment of 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.

_____ _____
Signature of Patient or Legal Representative **Date**

_____
Description of Legal Representative's Authority

Supporting legal documentation may be requested if being completed by an Authorized Representative

Staff Use Only	Documents Released:	To Be: ☐ Emailed ☐ Mailed ☐Faxed ☐Retrieved
Date:	MRN:	Staff Signature: