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 ☐HIV/AIDS/Sexually Transmitted Disease
☐Drug/Alcohol Treatment ☐Mental Health Information ☐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

***Unless revoked, this authorization will expire in* ☐6 months ☐ 1 year ☐ 2 years**

By signing this authorization, I understand that:

- I understand that my drug and/or alcohol treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and my health information is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Part 160 and 164. My information cannot be disclosed without my written authorization unless otherwise provided for by the regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to the 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.
- 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.

Patient/Legal Representative Signature: ______________ **Date:** ______________

Printed Name of Legal Representative: ______________ **Relationship to Patient:** ______________

If signed by an authorized representative, supporting legal documentation must accompany this authorization form

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

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). **The Federal rules prohibit you from making any further disclosure of this information** unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.