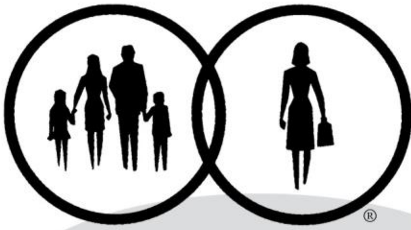

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AUTHORIZATION FOR DISCLOUSER OF HEALTH INFORMATION

I hereby authorize ____ Phone: _________________ Fax: ___________________

To disclosed the following information from the health records of:

Patient Name: ____ Date of Birth: __________________
Address: ____
Telephone: __________________________________ Social Security #: ____________________________

The information to be disclosed to: ____
____
____
____

Covering the periods of healthcare: from (date) ___________________ to (date) ______________________

Reason for Release: ____

Information to be disclosed:

__ Complete Health Record	__ Clinic Records	__Photos/digital images, etc
__Discharge Summary	__ Progress Notes	__ Operative Notes
__ History and Physical	__ Laboratory Tests	__Pathology Reports
__ Consultations	__ Emergency Room Reports	__ Radiology Reports
__ Medication Lists	__ Home Health/Hospice Records	

__ Other (please specify) ____

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or the human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment of drug and alcohol abuse.

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance to this authorization. Unless otherwise revoked, this authorization will expire six months from the date of signing.

Ravalli Family Medicine, its employees and physicians are hereby released from any legal responsibility or liability for disclosure of the above information.

I understand that any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of health information, I can contact someone in medical records or the privacy office of Ravalli Family Medicine.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_______________________________________ _______________________________________
Signature of Patient or Legal Representative Date

I signed by Legal Representative, indicate relationship to the patient: ____