Authorization To
RELEASE INFORMATION

Authorization for access to the records of:				
Last	First	Middle		Date of Birth
❑ Male	❑ Female	SS#	Former Name	Phone Number

Request information from (outside providers):			
Facility Name:		Phone Number	Fax Number
Address	City	State	Zip Code

Release information to:			
Name:			
Telephone Number (Include Area Code)		Fax Number (Include Area Code)	
Address:	City:	State:	Zip Code:

Information To Be Released:

Check all that apply:

- ❑ Medical Record
- ❑ Progress and treatment notes
- ❑ X-ray and/or Imaging Reports
- ❑ Laboratory Results
- ❑ Immunizations
- ❑ Mammogram
- ❑ Colonoscopy
- ❑ Prenatal
- ❑ OB Ultrasound
- ❑ Pathology Reports
- ❑ Billing Statements
- ❑ Prescriptions (Pharmacy records)
- ❑ Other:_____
- ❑ Most recent records pertaining to:

  _____

All records from this Date: _____ To this Date: _____

I give my permission to release the following records (Initial all that apply):

_____**HIV/AIDS and STD test results, diagnosis, or treatment records** MCA 50-16-1000
_____**Genetic testing information**
_____**Alcohol and Drug Abuse Records (Protected by Federal Confidentiality Rule 42 CFR Part 2**
_____**Details of Mental Health Diagnosis and/or Treatment provided by Licensed Mental Health Counselor**
_____**Details of Domestic Violence Victims' Counseling**
_____**Details of Sexual Assault Counseling**

I understand that all health care information, whether generated by you or by any other source may be released to me or to the designated person above for the purpose given. I may revoke this release in writing at any time, but I understand that revocation will not affect any information that was already released. This consent is valid for six (6) months or upon expiration date stated in the authorization, whichever is earlier. Exp._____/_____/20_____. A copy of this form is valid to give my permission to release records. MCA 50-16-531. One Health may charge to provide copies of its records. MCA-50-16-816.

AUTHORIZATION FOR RELEASE:

I authorize the following release of information from my records. I understand that information may be provided orally, by mail, fax, or hand delivery. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits. My questions about this authorization form have been answered.

AUTHORIZED BY (SIGNATURE)	**DATE SIGNED**	**TELEPHONE NUMBER (INCLUDING AREA CODE)**
PRINT NAME	**WITNESS (SIGN AND PRINT NAME, IF APPLICABLE)**	

If I am not the person whose records are being released. I am authorized to sign because I am the:

- ❑ Parent
- ❑ Legal Guardian (attach copy of court order)
- ❑ Other

To those receiving information under this authorization: Federal and state laws and regulations protect the information disclosed to you. You may not release it to any other person or entity without specific written consent. You are subject to the same standards and laws of confidentiality as the originating holder of the records.

INSTRUCTIONS FOR COMPLETION OF RELEASE FORM

Purpose: Use this form when you want a service or program at this facility to be able to share confidential information about you with another person (including and attorney, or a relative). You may use it to request all the records this facility has or you may limit the authorization to the records you specify. Any service in and all parts of this facility will recognize the permission given by this form. This release will also permit this facility to discuss your case verbally with the person you authorize. Most of the information this facility has about you is confidential and will not be disclosed to anyone else unless you grant permission.

Use of this form: A separate form must be completed for each person whose records are requested, including children. "You" in the instructions refers to the person whose records are being requested.

Parts of Form:

IDENTIFICATION OF SUBJECT OF RECORDS:

- Name: List your full name or the name of the person whose records are requested if you are authorizing release of information about someone else.
- Date of birth: Please include this information needed to identify you from persons with similar names.

OPTIONAL INFORMATION to help locate records:

- SS#: You may include a social security number that could help locate requested records.
- Former names: Including any other names that have been used when receiving services.

INFORMATION REQUESTED FROM (outside Providers):

- Facility Name: Clinic name and Dr. providing services that you are requesting health care records from.
- Phone/Fax Number: Provide Dr. or Clinic phone and/ or fax numbers – including area code.
- Address including City, State and Zip Code: of Dr. or Clinic

PERSON RECEIVING RECORDS:

- Identification: Please fill out this section as fully as possible so we can contact the person or program that will have access to the information.

AUTHORIZATION:

- Service Boxes: Please select the appropriate box representing the type of records you would like released.
- Information exchanged: Indicate all types of records that you want released. However, if the records include information about services involving, HIV/AIDS or STD testing or treatment, genetic testing, mental health, or drug and alcohol, you must initial each of these items specifically to grant permission to share this information.
- Validity: This form is valid to release information currently held by this facility or what it acquires within ninety days after signature or upon expiration date stated in the authorization, whichever is earlier. You may revoke the authority to release records at any time but it will be too late to take back information already given.
- Cost: The public disclosure law in MCA 50-16-512 allows this facility to charge for copies of its records under MCA 50-16-816 and CFR164.524

SIGNATURES:

- Authority: Sign and also print or type your name below. Insert the date you signed the form plus your telephone number to call if this facility has any questions. If you are signing for another person, indicate why you can do so in the last line and attach a copy of the court order or other document granting you this authority. Children must sign to authorize release of their own records if they are over the age of consent (13 for mental health and drug and alcohol services; 14 for information about HIV/AIDS or other STDs). Persons 18 and older must sign to authorize release of any records. If a witness is necessary, that person should sign and print his or her name in the marked box.

NOTICE WHEN EXCHANGING INFORMATION:

Please note that the information released is subject to the same confidentiality protections as it was at this facility. If you want us to release information to someone not listed on this form when signed, you must complete another release form.

NOTICE TO One Health: If any part of this facilities services sends copies of records regarding drug or alcohol services under this release, The services must include the following statement when disclosing information as required by 42 CFR 2.32:

"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 42 CFR 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."