COMMUNITY HEALTH PARTNERS
REAL PEOPLE. REMARKABLE HEALTHCARE.

[No label required,
scan to documents table]

PERMISSION TO DISCUSS HEALTH INFORMATION (HIPAA)

Patient Name	Date of Birth	Phone	
Address	City	State	Zip

I give permission for Community Health Partners to VERBALLY share my personal healthcare information with the family, friends, or others I identified below as being involved in my health care, care coordination or payment of my healthcare. This form DOES NOT authorize releasing copies of my medical records. Shared information may include:

- Scheduling/Appointment Information
- Medical information, including my symptoms, diagnosis, medications, and treatment plan.
  - This may include sensitive information including substance use and mental health treatment.
- Behavioral health information, including my symptoms, diagnosis, medications, and treatment plan.
  - This may include sensitive information including substance use and mental health treatment.
- Lab/Imaging Results
  - _____ Initial here to include results relating to sexually transmitted disease and HIV/AIDs
- Billing and Payment Information
- Other (describe): _____

Community Health Partners has my permission to discuss the following information (check all that apply) with:

	Name	Relationship	Phone	Schedule	Medical Info	Behavioral Health	Lab/Imaging Results	Billing	Other
1.				☐	☐	☐	☐	☐	☐
2.				☐	☐	☐	☐	☐	☐
3.				☐	☐	☐	☐	☐	☐

By signing this form, I understand that:

- If I have previously provided an "Permission to Discuss" form to CHP, it will be removed, and this form will be used.
- The information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment of alcohol or drug abuse.
- I understand that I have the right to revoke my permission at any time. Revocation must be made in writing and must be presented or mailed to the medical records department at the following address:
  CHP-Medical Records
  19 E. Main St.
  Belgrade, MT 59714
- I understand that revocation will not apply to information that has already been disclosed in response to this authorization.

Signature of Patient/Patient Representative:	Date:
Print Name of Patient/Patient Representative:	Relationship or scope of your legal authority to act on the patient's behalf:

Note: For copies of Medical Records, you will need to fill out a Release of Information. You can ask a CHP employee for a paper copy to fill out or you can fill out an electronic form on our website, chphealthmt.org.