COMMUNITY HOSPITAL OF ANACONDA

401 West Pennsylvania, Anaconda, MT 59711 Phone: 406-563-8500 FAX: 406-563-8565

AUTHORIZATION FOR DISCLOSURE OF PATIENT IDENTIFIABLE HEALTH INFORMATION

I hereby authorize Community Hospital of Anaconda to disclose the following information from the health records of:

Patient Name: _____Date of Birth: _____

Address: _____City / State: _____

Phone Number: _____ **Disclosed information will be used for**:

Self ___ Provider ___ Attorney ___ Insurance / Aflac ___ Other (specify) _____

This information is to be disclosed to: _____

_____

Disclosure Method: Pick-Up at Hospital ☐ Mail ☐ Email ☐_____ Fax ☐_____

Records covering the period(s) of healthcare: from (date) _____ to (date) _____

Information to be disclosed: (please check all that apply)

☐ Discharge Summary	☐ Progress Notes	☐ Operative Notes
☐ H & P	☐ Laboratory Tests	☐ Pathology Reports
☐ Consultations Reports	☐ ER Reports	☐ X-ray Reports
☐ Complete Health Record	☐ Other (please specify) _____	

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

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire six (6) months from the date of signing. If this authorization is for research, the authorization will expire at the end of the research study.

The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

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

Signature of Patient: _____**Date**: _____

(Or signature of Legal Representative) Legal Representative Relationship to patient_____

Records released by: _____ Date / Time _____ / _____LR20