AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

1930 9th Avenue, Helena, MT 59601 (406) 457-0000 phone (406) 457-8992 fax

PATIENT INFORMATION	NAME: ____________ DATE OF BIRTH:____________ Address: ____________ Day Phone:____________ City: ____________ State:_______ Zip:____________
Clinic/Hospital/Health Care Provider – (*Who* has the information you want released?) Please list the specific Hospital and/or clinic.	NAME: ____________ Address: ____________ Phone:____________ City:____________ State:_______ Zip:____________ Fax:____________
Receiving Party (*Where* do you want the information sent? *Who* may receive the information?)	NAME:____________ Attention To:____________ Address:____________ Phone:____________ City:____________ State:______ Zip:____________ Fax:____________
Information to be Released (*What* do you want sent or released? Check the appropriate box.)	Only records types checked below: _____ Discharge summary/note _____ Radiology reports _____Medication records _____ History & physical exam _____ Immunization/allergy record _____ Operative report _____ Laboratory reports _____ Progress notes/clinic notes _____ Pathology Reports _____ Other records specify record type(s) ____________ _____ All records Date(s) of service: ____________
	Items in this box will be released unless checked: ☐ Physician's Psychiatric Diagnoses ☐ Alcohol and Drug Info/Treatment ☐ AIDS/HIV/STD Testing and Results
Purpose of Release (*Why* is it needed?)	___ Continuing care ____Transfer of Care ___ Social security appeal ___ Insurance application * ____ Personal use or review ___ Social security disability determination* ___ Insurance payment/claim ____Litigation/legal * ___ Other*

- This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here:____________
- This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation. PureView Health Center Notice of Privacy Practice describes how to cancel (revoke) this authorization.
- PureView Health Center will not restrict my treatment if I choose not to sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- PureView Health Center cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release PureView Health Center from any and all liability resulting from a redisclosure by the recipient.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

____________________ Patient/Legal Guardian Signature ________ Date ____________________ Authority to act on behalf of patient (attach document)

____________________ Witness ________ Date