



# PUREVIEW | Health Center

## AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

1930 9<sup>th</sup> Avenue, Helena, MT 59601 (406) 457-0000 phone (406) 457-8981 fax

<b>PATIENT INFORMATION</b>	NAME: _____ DATE OF BIRTH: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____
<b>Clinic/Hospital/Health Care Provider –</b>  <i>(Who has the information you want released?) Please list the specific Hospital and/or clinic.</i>	NAME: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____ Fax: _____
<b>Receiving Party</b>  <i>(Where do you want the information sent? Who may receive the information?)</i>	NAME: _____ Attention To: _____ Address: _____ Phone: _____ City: _____ _____ State: _____ Zip: _____ Fax: _____
<b>Information to be Released</b>  <i>(What do you want sent or released? Check the appropriate box.)</i>	<u>Only records types checked below:</u> <input type="checkbox"/> Discharge summary/note <input type="checkbox"/> Radiology reports <input type="checkbox"/> Medication records <input type="checkbox"/> History & physical exam <input type="checkbox"/> Immunization/allergy record <input type="checkbox"/> Operative report <input type="checkbox"/> Laboratory reports <input type="checkbox"/> Progress notes/clinic notes <input type="checkbox"/> Pathology Reports <input type="checkbox"/> Other records specify record type(s) _____ <input type="checkbox"/> All records  Date(s) of service: _____
	<b>Items in this box will be released unless checked:</b> <input type="checkbox"/> Physician's Psychiatric Diagnoses <input type="checkbox"/> Alcohol and Drug Info/Treatment <input type="checkbox"/> AIDS/HIV/STD Testing and Results
<b>Purpose of Release</b>  <i>(Why is it needed?)</i>	<input type="checkbox"/> Continuing care <input type="checkbox"/> Transfer of Care <input type="checkbox"/> Social security appeal <input type="checkbox"/> Insurance application * <input type="checkbox"/> Personal use or review <input type="checkbox"/> Social security disability determination* <input type="checkbox"/> Insurance payment/claim <input type="checkbox"/> Litigation/legal * <input type="checkbox"/> Other*
<ul style="list-style-type: none"> <li>This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____</li> <li>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.</li> <li>PureView Health Center will not restrict my treatment if I choose not to sign this authorization.</li> <li>A photocopy/fax of this authorization will be treated in the same way as an original.</li> <li>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.</li> <li>Your signature indicates that you have read and understand this form, and authorize release of your information as described above.</li> </ul>	

\_\_\_\_\_  
Patient/Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authority to act on behalf of patient (attach document)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date