



PUREVIEW | Health Center

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

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

PATIENT INFORMATION	NAME: _____ DATE OF BIRTH: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____
Clinic/Hospital/Health Care Provider – <i>(Who has the information you want released?) Please list the specific Hospital and/or clinic.</i>	NAME: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____ Fax: _____
Receiving Party <i>(Where do you want the information sent? Who may receive the information?)</i>	NAME: _____ Attention To: _____ Address: _____ Phone: _____ City: _____ _____ State: _____ Zip: _____ Fax: _____
Information to be Released <i>(What do you want sent or released? Check the appropriate box.)</i>	<u>Only records types checked below:</u> ____ 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: <input type="checkbox"/> Physician's Psychiatric Diagnoses <input type="checkbox"/> Alcohol and Drug Info/Treatment <input type="checkbox"/> AIDS/HIV/STD Testing and Results
Purpose of Release <i>(Why is it needed?)</i>	____ Continuing care ____ Transfer of Care ____ Social security appeal ____ Insurance application * ____ Personal use or review ____ Social security disability determination* ____ Insurance payment/claim ____ Litigation/legal * ____ Other*
<ul style="list-style-type: none"> 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