AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

☐ **St. Peter's Hospital**
Medical Records Department
2475 Broadway
Helena, MT 59601
Phone: (406) 444-2178
Fax: (406) 447-2627

☐ **St. Peter's Medical Group~Broadway**
Medical Records Department
2550 Broadway
Helena, MT 59601
Phone: (406) 495-6882 or (406) 495-6883
Fax: (406) 495-6885

☐ **St. Peter's Medical Group~North**
Medical Records Department
3330 Ptarmigan Lane
Helena, MT 59602
Phone: (406) 495-7967
Fax: (406) 495-7969

Patient Name:_____ Date of Birth:_____

SSN:_____ Phone:_____

To receive information about me from:

FROM:_____
Hospital, Agency, Physician, etc.

_____
Address.

_____

_____
Phone/Fax

I hereby authorize designated staff of St. Peter's to disclose protected health information about me to (provide the full name or other specific identification of the person or class of person(s) to whom the disclosure may be made):

Send TO: Dr Michael Uphues, DO
Hospital, Agency, Physician, etc.

3600 Marathon Drive
Address

Billings, MT 59102

406-969-2447
Phone/Fax

The Information to be released is to be used for the purpose of:

☐ Attorney ☐ Personal ☐ At the request of the individual (1)
☐ Workers Comp. ☐ Disability ☐ Other:_____

I request the release of the following specific information for specific dates of service:

☐ History & Physical ☐ Pathology Report ☐ Medication Sheet
☐ Office/Progress Note ☐ Operative Report ☐ Entire Visit Date:_____
☐ Consult ☐ Discharge Summary ☐ Entire Record
☐ X-ray ☐ Physician Order ☐ Immunization
☐ Laboratory Report ☐ Emergency Services ☐ Other:_____

Specific Treatment Dates:_____

Terms and Conditions of Release:

- You have the right to revoke this authorization by doing so in writing and submitting your request to the Medical Records Department of St. Peter's. Your revocation will not apply to information that has already been disclosed in reliance on this authorization.
- Authorizing the use of disclosure of information identified above is voluntary, and I need not sign this form to obtain healthcare treatment.
- Once the information is disclosed, it may be subject to re–disclosure by the recipient, and federal privacy laws or regulations may no longer protect the information.
- I release the above named facility from liability and claims of any nature pertaining to the disclosure of requested protected health information pursuant to this authorization.
- This authorization expires upon occurrence of _____or on the following date _____(but not more than 12 months from the date of this authorization).

Signature:_____ **Date:**_____

Relation to Patient: ☐ Parent ☐ Guardian ☐ Spouse ☐ Personal Representative ☐ ID Verified_____

(1) If a patient is unable to give consent, provide a reason:_____