Billings Clinic

Health Information Management- Release of Information
P.O. Box 31598, Billings, MT 59107
(406) 657-4676 FAX (406) 657-4348

Authorization to Disclose Health Care Information

Patient Name: _____ Date of Birth: _____/_____/_____

Phone: (_____) _____ Cell Phone: (_____) _____

I request my protected health information (PHI) from: (please check all that apply)-Billings Clinic

☑ Billings Clinic ☑ Billings Clinic Hospital ☐ Behavioral Health Clinic ☐ Billings Clinic Psychiatric Center
☐ Red Lodge Clinic (Prior to November 18, 2010) ☐ Columbus Clinic (Prior to September 10, 2012)

I request my protected health information (PHI) to be: used or disclosed to following person, class of persons, or organization: ☐ release of medical records or ☐ verbal discussion ☐ No records sent at this time please keep on file

Name: Dr Michael Uphues, DO Caduceus Medical Partners, LLC Fax: 406-969-2447
Address: 3600 Marathon Drive
City: Billings State: MT Zip: 59102

I request my protected health information (PHI) to be released from my medical record(s): (Please check all that apply or describe the information specifically):

☑ Hospital Medical Records ☑ Clinic Medical Records ☐ Immunization Records ☑ Pathology Reports
☑ X-Ray Reports ☐ Psychiatric Records ☐ Billing Records ☑ Outpatient Pharmacy Records
☑ Radiology Disc ☐ Pathology Slides (Only Released to Other Health Care Facilities)
☐ Specific Date(s):_____ to _____ ☐ Provider's Name:_____
☐ Other_____
_____

I authorize the release of information in my health record which may include information related to:

☐ Behavioral or Mental Health Issues ☐ Sexually Transmitted Diseases ☐ Sexual Assault Nurse Examiner Reports
☐ Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)
☐ Alcohol and Drug Treatment

Purpose for requesting information: (Please check one)

☑ Request of Patient ☐ Continuation of Care ☐ Other: _____

Unless otherwise revoked, this authorization will expire on the following date. If you do not indicate an expiration date, it expires six months after it is signed. If you wish for this authorization to expire when an event occurs, please describe the event in detail (i.e. when the records have been sent).

☑ 3 months ☐ 6 months ☐ Event_____

By signing this authorization, I understand that:

- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to the Billings Clinic Health Information Management Department. I understand that I cannot revoke authorization for information that has already been released in response to this authorization. Additional information regarding the individual's right to revoke an authorization is found in Billings Clinic's Notice of Privacy Practices.
- I understand that this authorization is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive treatment, payment for services, enrollment or eligibility for benefits. I understand that I may inspect or copy this authorization as provided in 45 CFR 164.524.
- I understand that any disclosure of information under this authorization carries with it the potential for an unauthorized re-disclosure by the recipient and, after it is disclosed, the information may not be protected by state or federal confidentiality rules.
- If I have questions about disclosure of my health information, I can contact Billings Clinic Health Information Management Department.

Patient/Authorized Representative* Signature:_____ Date:_____ Time:_____

Printed Name of Authorized Representative:_____ Relationship to Patient:_____

*If signed by a patient's authorized representative, supporting legal documentation must accompany this authorization form.