MARCUS DALY MEMORIAL HOSPITAL
Quality Care Close to Home™

Fax: 375-4660

1200 Westwood Drive
Hamilton, Montana 59840
(406) 363-2211

MRN: _____

CHECK ALL THAT APPLY:

- ❑ HOSPITAL
- ❑ HOME HEALTH/HOSPICE
- ❑ RADIOLOGY
- ❑ CLINIC *(SPECIFY)*: _____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION FROM MDMHC

(1) I hereby authorize **Marcus Daly Memorial Hospital Corporation and/or its associated clinics** to disclose the following information from the health records of:

Patient Name: _____ Date of Birth: _____
FIRST, MI, LAST *MONTH / DAY / YEAR*

Street Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

(2) This information is to be disclosed to: ❑ SELF *OR:* Name: Dr Michael Uphues, DO

Address: 3600 Marathon Drive

Billings, MT 59102

_____
PHYSICIAN NAME ***(REQUIRED FOR CONTINUING CARE)***

Phone: (406) 696-0409 Fax: (406) 969-2447

(3) The information to be disclosed will be used for the following purpose:

- ☒ Patient Request
- ☒ Continuing Care
- ❑ Disability
- ❑ Insurance
- ❑ Work Comp
- ❑ Subpoena/Court Order
- ❑ Legal (Non Subpoena or Court Order)
- ❑ Government Agency
- ❑ Other: _____

(4) Covering the periods of healthcare: From (date): _____ To (date): _____

From (date): _____ To (date): _____

(5) Information to be disclosed:

- ❑ Discharge Summary
- ☒ History and Physical Examination
- ☒ Consultation Reports
- ❑ Photos, Videos, Digital or other images
- ☒ Progress Notes
- ☒ Physician's Orders
- ❑ Other *(please specify)*: _____
- ☒ Emergency Room Records
- ☒ Operative Note
- ☒ X-Ray Report
- ❑ X-Ray Image(s) burned to disc
- ❑ Laboratory Tests
- ☒ Pathology Report
- ❑ Cardiology Tests
- ☒ PT/OT/Speech Therapy Notes
- ❑ Home Health/Hospice Records
- ☒ Clinic Records
- ❑ Complete Health Record

(6) I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug use.

(7) I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire six (6) months from the date of signing.

(8) The facility, it's employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

(9) I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management (HIM) Department Head, or, the Privacy Officer of Marcus Daly Memorial Hospital Corporation.

(10) I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____
Signature of Patient or Legal Representative Date

If signed by Legal Representative, indicate relationship to the patient: _____

FOR OFFICE USE ONLY:

ACTION TAKEN

- ❑ Released by Clinic (Continuing Care only)
- ❑ Released by Radiology
- ❑ Released by HIM
- ❑ Routed to HIM for Completion and Release

DELIVERY METHOD

- ❑ Walk-in
- ❑ Faxed
- ❑ Mailed

RELEASE TRACKING

Number of pages: _____ ❑ Radiology CD

Date Completed: _____

Initials: _____

Authorized by: _____ *(Required if released by exception.*