Print Clear

Medical Record #_____

Patient Information

Full Name _____ Date of Birth _____

Maiden or Other Names Used _____ Social Security Number: XXX-XX-_____ (last 4 digits)

Address _____

Day Phone #_____ Cell # _____ City State Zip

Release From

Care Site Name SAINT JAMES HOSPITAL

Address _____ BUTTE MT 59701

Phone # _____ Fax # _____ City State Zip

Release To

Person/Company/Organization Name DR. MICHAEL UPHUES, DO /Caduceus Medical Partners, LLC

Address 3600 Marathon Drive BILLINGS MT 59102

Phone # 406-696-0409 Fax # 406-969-2447 City State Zip

Purpose

☑ Continuation of Care ☐ Insurance/WC ☐ Legal
☐ Personal ☐ Other (specify): _____

Date(s) Of Information To Be Released

Date(s) of Service from _____ through _____
Date(s) of Service from _____ through _____

Information To Be Released/Accessed I would like copies of the items checked below for the treatment dates listed above.

☑ Emergency Report ☑ Discharge Summary ☑ History & Physical ☐ Imaging CD/Film (MRI/CT/X-Ray/Ultrasound)
☑ Operative Report ☑ Consultation ☑ Laboratory ☑ Imaging Report
☑ Clinic Visit ☐ Billing Records ☐ Cardiac Studies/EKG ☐ Other: _____

Disclosure/Access Format I would like copies of the items checked above in the following format: (Paper format–US Mail is default if not marked)

☐ Paper format – US Mail ☐ CD ☑ Fax (healthcare provider only)
☐ Paper format – pick up ☐ Review only ☐ Email to: _____

Patient Access Information

- I will provide a picture ID prior to accessing my medical record.
- I may review my medical record without a charge. If I request copies of my medical record, I may be charged a fee.
- I will refer my questions regarding treatment, prognosis, or other clinical matters to my physician.
- A Care Site professional will supervise the review of my medical record.
- If I am involved in a research study involving medical treatment, my access to the research study content may be temporarily suspended for as long as the research is in progress. At the completion of the research, access to my medical record will be reinstated.

I Understand That

- The information to be released may include a diagnosis or reference to the following condition(s): *behavioral health services/psychiatric care; sickle cell anemia; genetic testing; acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV); or drug and/or alcohol abuse.*
- Without my express revocation, this authorization will automatically ***expire*** 180 days from the date signed below, unless I request an expiration date less than 180 days.
- I may ***revoke*** this authorization in writing at any time, except to the extent that action has already been taken to comply with it.
- Information disclosed pursuant to the authorization may be subject to ***redisclosure*** by the recipient and is no longer protected by the HIPAA Privacy rule.

My signature is required to validate this authorization. If I do not sign this authorization, this Care Site will still provide treatment and seek payment for services provided. According to State Statutes, this care site may charge for copies of medical records.

_____

Signature of Patient/Guardian/Personal Representative Relationship (if not patient) Date

_____

Personal Representative's PRINTED Name, Address, and Phone Number

If patient is unable to sign, document reason: _____

For Office Use Only

Date Authorization Received: _____ By: _____ Identification/Driver's License # Verified: _____
Date Request Completed:_____ By: _____ Delivery Instructions: _____

SCL Health System
Sisters of Charity of Leavenworth Health System

ON107

Authorization for Release/Disclosure of Protected Health Information (PHI)

EH-FR-MR-0215-0314-SCLHS

PATIENT INFORMATION

Place label here.
Scanning does NOT work if label is outside this guide.