



AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH CARE INFORMATION

I hereby authorize **COMMUNITY MEDICAL CENTER** 2827 Fort Missoula Road, Missoula, MT 59804 (406) 728-4100 to release information from the medical records of: Phone # _____

Patient's Name (please print)	Date of Birth	SSN#
To: Dr Michael Uphues, DO 3600 Marathon Dr., Billings, MT 59102 Fax: 406-969-2447		
Party to receive information	Address	

This information for which I'm authorizing disclosure will be used for the following purpose:

- My personal records
- Sharing with other health care providers as needed
- Other (please describe): _____

The type of information to be used or disclosed is as follow (check the appropriate boxes and include other information where indicated):

<input checked="" type="checkbox"/>	Type of Information Requested:	Lab Results - specify date(s) or type of labs to be disclosed:
<input checked="" type="checkbox"/>	Discharge Summary	
<input checked="" type="checkbox"/>	X-ray Report	Consultation Report from Dr.
<input type="checkbox"/>	Immunization Records	Entire Record
<input checked="" type="checkbox"/>	History and Physical	
<input type="checkbox"/>	EKG	
<input checked="" type="checkbox"/>	ER Record	Other: (please describe)
<input type="checkbox"/>	Specified Date(s) of service if known:	

I understand that the records released may contain the following information, which is protected by state and/or federal law, and authorize you to release this information (you must initial all those that apply):

- _____ *Mental Health Treatment
- _____ *Drug and Alcohol Abuse
- _____ *Aids/HIV related information

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless I specify differently, this authorization will expire (insert date or event) 2/2017. If I fail to specify an expiration date or event, this authorization will expire in six months from the date on which it was signed. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal or state privacy laws or regulations. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I acknowledge that I may be charged a reasonable, cost-based fee for making copies. I acknowledge that third-party payers and other parties requesting health information on behalf of myself with my authorization will be charged as state laws allow.

Signature of patient or legal representative _____ Date _____

Relationship to Patient _____

Community Medical Center, 2827 Fort Missoula Road, Missoula Montana 59804
Health Information Management Department
Phone: 406-327-4085
Fax: 406-327-4510

12/07:8311-10A/25046