

Health Information Management- Release of Information  
620 S. Haynes Avenue, Miles City, MT 59301  
(406) 233-7012 FAX (406) 233-7085

**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  
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.