



## Authorization to Disclose Protected Health Information

<b>Patient Information</b>	Name: _____ Date of Birth: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____																		
<b>Hospital/Clinic/Health Care Provider</b> <small>(Who has the information you want released? Please list the specific hospital and/or clinic.)</small>	Glacier Ear, Nose and Throat 160 Heritage Way Kalispell, MT 59901 Phone: (406) 752-8330, Fax: (406) 752-8412																		
<b>Receiving Party</b> <small>(Where do you want the information sent? Who may have the information?)</small>	Name: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____ Fax Number: _____																		
<b>Information to be Released</b> <small>(What do you want sent or released? Check the appropriate box.)</small>	Date range of information to be released: From: _____ To: _____ (Month/Year) (Month/Year)  Please check specific information to be released: <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Entire Record</td> <td><input type="checkbox"/> Emergency Record(s)</td> <td><input type="checkbox"/> Mammogram <input type="checkbox"/> reports <input type="checkbox"/> films/CD</td> </tr> <tr> <td><input type="checkbox"/> Discharge Summary / Note</td> <td><input type="checkbox"/> Pathology Reports</td> <td><input type="checkbox"/> Ultrasound <input type="checkbox"/> reports <input type="checkbox"/> films/CD</td> </tr> <tr> <td><input type="checkbox"/> History and Physical</td> <td><input type="checkbox"/> Laboratory Reports</td> <td><input type="checkbox"/> X-ray <input type="checkbox"/> reports <input type="checkbox"/> films/CD</td> </tr> <tr> <td><input type="checkbox"/> Consultation Report</td> <td><input type="checkbox"/> Medication List</td> <td><input type="checkbox"/> Billing</td> </tr> <tr> <td><input type="checkbox"/> Operative Report</td> <td><input type="checkbox"/> CT <input type="checkbox"/> reports <input type="checkbox"/> films/CD</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td><input type="checkbox"/> Progress Notes</td> <td><input type="checkbox"/> MRI <input type="checkbox"/> reports <input type="checkbox"/> films/CD</td> <td></td> </tr> </table>	<input type="checkbox"/> Entire Record	<input type="checkbox"/> Emergency Record(s)	<input type="checkbox"/> Mammogram <input type="checkbox"/> reports <input type="checkbox"/> films/CD	<input type="checkbox"/> Discharge Summary / Note	<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Ultrasound <input type="checkbox"/> reports <input type="checkbox"/> films/CD	<input type="checkbox"/> History and Physical	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> X-ray <input type="checkbox"/> reports <input type="checkbox"/> films/CD	<input type="checkbox"/> Consultation Report	<input type="checkbox"/> Medication List	<input type="checkbox"/> Billing	<input type="checkbox"/> Operative Report	<input type="checkbox"/> CT <input type="checkbox"/> reports <input type="checkbox"/> films/CD	<input type="checkbox"/> Other _____	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> MRI <input type="checkbox"/> reports <input type="checkbox"/> films/CD	
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<b>Release Instructions</b> <small>(How and when do you want the information?)</small>	Date information is needed: _____ <b>(Note: Please allow 7-10 days for processing)</b> Disclosure Method: <input type="checkbox"/> Pickup <input type="checkbox"/> Mail <input type="checkbox"/> CD <input type="checkbox"/> Fax # _____ Email Address _____ <b>Note: Records that are e-mailed will NOT be sent through a secure e-mail server. By choosing this option and signing below, Patient accepts responsibility for any privacy risks associated with email disclosure.</b> <input type="checkbox"/> Other _____ <b>Note: *Fees may be charged in accordance with Federal and State law.</b>																		
By signing this authorization form, I understand that:																			
<ul style="list-style-type: none"> <li>The information in the health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) and genetic information. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.</li> <li>This authorization does not apply to psychotherapy notes.</li> <li>Once the information described herein is disclosed, it could be redisclosed by the recipient and may not be protected by privacy protections.</li> <li>I have the right to revoke this Authorization at any time. Revocation must be in writing and presented to Glacier Ear, Nose &amp; Throat (fax 406-752-8412). Revocation will not apply to information that has already been disclosed in response to this Authorization.</li> <li>Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this Authorization.</li> <li>Requests for copies of health records are subject to reproduction fees in accordance with Federal and State law. Full records - \$10 plus \$.50/page. Partial records - \$.50/page.</li> <li>I will receive a copy of this Authorization.</li> <li>Unless otherwise revoked, this Authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this Authorization will expire six (6) months from the date it is signed.</li> </ul>																			
Signature of Patient or Legal Representative	Printed Name	Date																	
If signed by Legal Representative, Relationship to Patient	Signature of Witness	Printed Name																	
<b>For Office Use Only:</b>																			
Signature/ID verified <input type="checkbox"/> Yes <input type="checkbox"/> No	Completed by _____	# of pages released _____																	
MRN/Log #: _____	Name/Date _____																		
<b>Revocation Authorization</b>	I hereby revoke (cancel) this Authorization to Disclose Protected Health Information. Cancellation Signature: _____ Date: _____																		