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| **Patient Information** | Name: Date of Birth:  Address: Day Phone:  City: State: Zip: | | | |
| **Hospital/Clinic/Health Care Provider**  (Who has the information you want released? Please list the specific hospital and/or clinic.) | Glacier Ear, Nose and Throat  160 Heritage Way  Kalispell, MT 59901  Phone: (406) 752-8330, Fax: (406) 752-8412 | | | |
| **Receiving Party**  (Where do you want the information sent? Who may have the information?) | Name:  Address: Day Phone:  City: State: Zip:  Fax Number: | | | |
| **Information to be Released**  (What do you want sent or released? Check the appropriate box.) | Date range of information to be released: From: To:  (Month/Year) (Month/Year) | | | |
| Please check specific information to be released: | | | |
| □ Entire Record  □ Discharge Summary / Note  □ History and Physical  □ Consultation Report  □ Operative Report  □ Progress Notes | | □ Emergency Record(s)  □ Pathology Reports  □ Laboratory Reports  □ Medication List  □ CT □ reports □ films/CD  □ MRI □ reports □ films/CD | □ Mammogram □ reports □ films/CD  □ Ultrasound □ reports □ films/CD  □ X-ray □ reports □ films/CD  □ Billing  □ Other |
| **Release Instructions**  (How and when do you want the information?) | Date information is needed: **(Note: Please allow 7-10 days for processing)**  Disclosure Method: □ Pickup □ Mail □ CD □ Fax #  **Note**: \*Fees may be charged in accordance with Federal and State law. | | | |
| By signing this authorization form, I understand that:   * 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. * This authorization does not apply to psychotherapy notes. * Once the information described herein is disclosed, it could be redisclosed by the recipient and may not be protected by privacy protections. * I have the right to revoke this Authorization at any time. Revocation must be in writing and presented to Glacier Ear, Nose & Throat (fax 406-752-8412). Revocation will not apply to information that has already been disclosed in response to this Authorization. * Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this Authorization. * Requests for copies of health records are subject to reproduction fees in accordance with Federal and State law. Full records - $15 plus $.50/page. Partial records - $.50/page. * I will receive a copy of this Authorization. * 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. | | | | |
| Signature of Patient or Legal Representative Printed Name Date    If signed by Legal Representative, Relationship to Patient Signature of Witness Printed Name | | | | |
| **For Office Use Only:**  Signature/ID verified □ Yes □ No Completed by # of pages released  MRN/Log #: Name/Date | | | | |
| **Revocation Authorization** | | *I hereby revoke (cancel) this Authorization to Disclose Protected Health Information.*  *Cancellation Signature: Date:* | | |