FALLON MEDICAL COMPLEX
"Friends Healing Friends"

PO Box 820
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Baker, MT 59313-082
(406) 778-3331
FAX (406) 778-5455

Authorization for Access, Use and Disclosure of Protected Health Information (PHI)

Patient Full Legal Name:			Birth Date:
Address:		City:	
State:	Zip Code:	Day Phone #:	Cell #:

Release From:			
Facility Name			
Address:		City:	State:
Zip Code:	E-mail Address:	Phone #	Fax #

Release To:			
Facility/Person/Company/Organization Name:			
Address:		City:	State:
Zip Code:	E-mail Address	Phone#	Fax #

Purpose: ❑ Continuation of Care ❑Personal ❑ Insurance/WC ❑ Legal ❑ Other (specify): _____

Information To Be Released: I would like copies of the items checked below:
❑ Emergency Report ❑ Discharge Summary ❑ History & Physical ❑ Clinic Provider Report
❑ Laboratory ❑ EKG ❑ Pathology Report ❑ Rehabilitation
❑ Imaging (MRI/CT/X-RAY/Ultrasound/Mammogram)
❑ Billing Itemized ❑ Billing Claim Form ❑ Entire Medical Record
❑ Other (specify): _____

For the treatment dates listed: Covering records for the period from _____ to _____

Disclosure Format:

❑ Paper format- US Mail ❑ Electronic- Disc ❑ Electronic Fax ❑ Review Only
❑ Paper format- Pick up ❑ USB Drive ❑ Other (specify): _____
❑ Email (Size limits applies. If too large a disc will be mailed).**
****Health Information sent via <u>unencrypted email</u> may place risk of inappropriate access to the information contained within the email. ****

I accept the risk if I direct Fallon Medical to send my health information via unsecure means. *Init.* _____

The information to be released may include a diagnosis or reference the following condition(s): Please check all that apply:
❑ Behavioral/mental health care ❑ Mental/physical/sexual abuse ❑ Sickle cell anemia ❑ Genetic testing
❑ Acquired immune deficiency syndrome (AIDS) or human immunodefiency virus (HIV) ❑ Sexually transmitted disease
❑ Drug and/or alcohol substance use/abuse disorders. ***Init.*** _____

CONTINUED ON OTHER SIDE >>>>>>>>>>

The following information which includes a diagnosis or reference the following condition(s) may NOT be released: Please check all that apply:

❑ Behavioral/mental health care ❑ Mental/physical/sexual abuse ❑ Sickle cell anemia ❑ Genetic testing
❑ Acquired immune deficiency syndrome (AIDS) or human immunodefiency virus (HIV) ❑ Sexually transmitted disease
❑ Drug and/or alcohol substance use/abuse disorders. ***Init.*** _____

Patient Access/Release Information

- I will submit a copy of a picture ID if requesting information by fax, mail, or email.
- 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 receive the first copy without a charge, additional copies may be charged.
- I will refer my questions regarding treatment, prognosis, or other clinic matters to my physician.
- A HIM professional will supervise the review of my medical record.

I Understand That

- Without my express revocation, this authorization will automatically **expire 1 year** from the date signed below, unless I request an expiration date less than 1 year. 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 re-disclosure by the recipient and is **no longer protected by the HIPAA Privacy Rule,** unless the disclosed includes records from a federally-assisted programs specifically proving diagnosis, treatment or referral for treatment of drug and alcohol abuse, in which case redisclosure is prohibited under
  42 CFR Part 2.
- The disclosed information above may, in some instances, be re-disclosed by the individual/entity receiving the information In these instances the disclosed information is **no longer protected by the HIPAA Privacy Rule and FMC is not responsible for its disclosure**
- **NOTE:** Protected health information obtained after the date of the signature may not be released under this authorization. An individual cannot authorize release of records that have not yet been created.
- Fallon Medical Complex will not condition treatment on whether the individual sign the authorization.
- The above individual (patient/resident/legal representative) may inspect or receive a copy protected health information to be used or disclosed as provided in **§164.524 of the Privacy Act.**
- All release of information payments will be made directly to Fallon Medical Complex when fees are applicable.

Patient/Authorized Representative* Signature:	**Date:**
Printed Name of Authorized Representative:	***Relationship to Patient:***
****If you are an authorized representative (other than a parent of a minor child), you will need to provide documentation of your authority to act for the patient (e.g., Health Care Power of Attorney).**	

For Office Use Only	
Witnessed Signature:	**Date:**
Date Released:	***Released by:***