Authorization to Disclose Protected Health Information

Date:	Patient Name:	Phone:
Date of Birth:	SSN:	

☐ Flathead Valley Orthopedic Center, PC
111 Sunnyview Lane
Kalispell, MT 59901
Phone: 406.752.7900
Fax: 406.257.0253

☐ _____
_____
_____

This information may be given to and used by the following individual or organization:

Information to be used for the purpose of:

_____

Disclosure Method
☐ Pickup ☐ Mail ☐ Fax #

I hereby request and authorize you to release information to:

Name: _____

Address: _____

_____

I authorize the use or disclosure of the above named individual's health information as described below:

Information to be released

☐ Office Records from _____ to _____
☐ Progress Notes from _____ to _____
☐ X-ray Report
☐ X-ray pictures on CD from _____to_____
Body Part_____
☐ MRI Report
☐ MRI pictures on CD from _____to_____
Body Part_____
☐ Office Tests & Procedures (list)
☐ Other _____
☐ Account information
☐ Records from other parties or facilities

I understand that the information in my health record may include information relating to sexually transmitted disease, behavioral or mental health services, and treatment for alcohol and drug abuse.

- **I understand there will be a charge for copying records and a $3.00 charge for X-ray/MRI CD's.**
- I understand that if the person or entity that receives the information is not a health care provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in the federal privacy regulations.
- Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____ If I fail to specify an expiration date, even or condition, this authorization will expire in six months.
- I understand that I may revoke this authorization in writing at any time by contacting the Privacy Officer at 406.752.7900
- I understand that this revocation does not apply to information that has already been released in response to this authorization.
- Failure to sign this authorization:
  ☐ Will have no adverse impact on delivery of care or reimbursement of patient charges.
  ☐ Will have the following adverse impact: _____

_____
Signature of Patient or Legal Representative Date

_____
If signed by Legal Representative, Relationship to Patient Signature of Witness

I Revoke (cancel) this Authorization to disclose Health Information previously signed on _____(date)

_____
Cancellation Signature Date