

Health Information Management- Release of Information
P.O. Box 31598, Billings, MT 59107
(406) 657-4676 FAX (406) 657-4348

**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

- | | | | |
|--|--|---|---|
| <input checked="" type="checkbox"/> Billings Clinic | <input checked="" type="checkbox"/> Billings Clinic Hospital | <input type="checkbox"/> Behavioral Health Clinic | <input type="checkbox"/> Billings Clinic Psychiatric Center |
| <input type="checkbox"/> Red Lodge Clinic (Prior to November 18, 2010) | <input type="checkbox"/> 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 CADUCEUS MEDICAL PARTNERS, LLC FAX: 406-969-2447

Address: 724 GRAND AVENUE

City: BILLINGS State: MT Zip: 59101

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):

- | | | | |
|--|---|---|---|
| <input checked="" type="checkbox"/> Hospital Medical Records | <input checked="" type="checkbox"/> Clinic Medical Records | <input type="checkbox"/> Immunization Records | <input checked="" type="checkbox"/> Pathology Reports |
| <input checked="" type="checkbox"/> X-Ray Reports | <input type="checkbox"/> Psychiatric Records | <input type="checkbox"/> Billing Records | <input checked="" type="checkbox"/> Outpatient Pharmacy Records |
| <input checked="" type="checkbox"/> Radiology Disc | <input type="checkbox"/> Pathology Slides (Only Released to Other Health Care Facilities) | | |
| <input type="checkbox"/> Specific Date(s): _____ to _____ | | <input type="checkbox"/> Provider's Name: _____ | |
| <input type="checkbox"/> Other _____ | | | |

I authorize the release of information in my health record which may include information related to:

- | | | |
|--|--|--|
| <input type="checkbox"/> Behavioral or Mental Health Issues | <input type="checkbox"/> Sexually Transmitted Diseases | <input type="checkbox"/> Sexual Assault Nurse Examiner Reports |
| <input type="checkbox"/> Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) | | |
| <input type="checkbox"/> 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.