AUTHORIZATION FOR USES & DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations				
Patient name:		**Birth Date:**	SSN (optional):	
Requestor's Name (If other than patient):	Recipient's Name (To whom would you like this information disclosed): Dr Michael Uphues, DO Fax: 406-969-2447			
Requestor's Address:	Recipient Address: 724 GRAND AVENUE			
	City: Billings	State: Mt	Zip: 59101	
This authorization will expire six months after date of signature or as specified below: **Date:**				
Purpose of Disclosure: Continuation of care				
Description of information to be used or disclosed				
Description:	Date(s):	Description:	Date(s):	
☐ Radiology Report(s) X		☒ Discharge Summary Report X		
☒ Lab Report(s) X		☐ All PHI in medical record X		
☐ ER Report X		☐ Radiology films (Rad. Dept.) X		
☒ Dictation reports X		☐ Other:		

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, HIV, psychiatric information. I understand that such information cannot be released without my specific consent, except under a Court Order. It is my intent that information released is prohibited for any other purpose than that which is stated above.

I understand that:

1. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization
2. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
4. I understand that I may see and obtain a copy of the information described on this form, if I ask for it.
5. I may be charged $15 administrative fee, plus $.50/page if requesting all PHI in record.
6. I get a copy of this form after I sign it.

Section B: Signatures:		
I have read the above and authorize the disclosure of the protected health information as stated.		
Signature of Patient/Guardian/ Patient Representative:	Time:	Date:
Print Name of Patient/Patient Representative	Relationship or scope of your legal authority to act on the patient's behalf:	

Bozeman Deaconess HEALTH SERVICES

915 Highland Boulevard
Bozeman, MT 59715

PATIENT LABEL:

Instructions:

Please complete, date and sign the attached form then return.

Telephone:
406-414-1055

Fax:
406-414-1069

By mail:
Bozeman Deaconess Medical Records Department
915 Highland Boulevard
Bozeman, MT 59715
ATTN: medical records department

Your request is being processed in the order of which it's been received. Your records will be sent by mail within 7 working days. Thank you for contacting Bozeman Deaconess Hospital.