NORTH VALLEY HOSPITAL

1600 Hospital Way ● Whitefish, MT
Phone (406) 863-3547 ● Fax (406) 863-3645

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient: _____ Date of Birth: _____
Address: _____
_____
Telephone: _____

Other names under which the Patient has been treated: _____

I authorize North Valley Hospital and its clinics, employees, agents, or associated healthcare practitioners ("PROVIDER") to use or disclose the Patient's protected health information as described below.

1. **Relevant Time Period.** PROVIDER may use or disclose information relating to healthcare provided during the following time period:
   - ☑ Anytime.
   - ☐ Healthcare provided between (*date*) _____ and (*date*) _____.

2. **Types of Information.** PROVIDER may use or disclose the following type(s) of information:
   - ☑ Any information concerning the Patient's healthcare or payment during the relevant time period.
   - ☐ Medical records concerning the Patient's healthcare during the relevant time period, including:
     - ☑ Records from the Patient's chart (*e.g.*, history, examination, progress notes, lab results, diagnostic test results, operative reports, discharge summaries, photographs, *etc*.)
     - ☑ Diagnostic images, films or other recordings (*e.g.*, x-rays, MRI scans, CT scans, *etc*.)
     - ☑ Psychotherapy notes ***[Note: These cannot be combined with authorization for other records]***
   - ☐ Billing and payment records for healthcare rendered during the relevant time period.
   - ☐ Other: _____

3. **Persons to Whom Disclosure Allowed.** PROVIDER may disclose the information to the following entity (ies):
   Name or description: Dr. Michael Uphues, DO Caduceus Medical Partners, LLC
   Address: 724 Grand Avenue, Billings, MT 59101
   Phone number: Office Phone: 406-696-0409 Fax- 406-591-4465

4. **Purpose.** PROVIDER may use or disclose the information for the following purpose(s):
   - ☑ The disclosure is made at the Patient's request.
   - ☐ For a potential or pending legal proceeding.
   - ☐ For marketing. PROVIDER *will/will not (circle one)* receive remuneration form a third party for the use or disclosure of the information.
   - ☐ Other: _____

I understand that I have the right to revoke this authorization at anytime except to the extent that PROVIDER has taken action in reliance on this authorization. To revoke this authorization, I must submit a written revocation to the Director of Health Information Management at North Valley Hospital.

I understand that PROVIDER may not condition the Patient's healthcare on this authorization unless (1) the purpose for PROVIDER's evaluation and treatment is to obtain and disclose information to entities consistent with this authorization, or (2) the Patient is involved in research-related treatment and the use or disclosure is for such research.

I understand by signing this authorization, above information may include alcohol, drug abuse, mental and/or other highly confidential information health records obtained in the course of my diagnosis and treatment.

I understand that I may inspect or obtain a copy of PHI to be disclosed, and may refuse to sign authorization.

I understand that information disclosed by PROVIDER pursuant to this authorization may be re-disclosed by the entity who receives this information and may no longer be protected by privacy regulations.

This authorization will expire on the following date or event: 3 months. If no specific date or event is stated, this authorization will expire six (6) months from the date of this authorization.

_____ _____
Signature Date

_____
Authority or relationship to the Patient

** Give a copy of the authorization to the Patient or personal representative.*