Fax: 406-488-2127

SIDNEY HEALTH CENTER

Authorization for Release of Health Care Information

PATIENT IDENTIFICATION:

_____ _____

Patient Name (please print full name) Previous/Maiden Name

Address: _____ Date of Birth: _____

_____ Telephone No.: _____

AUTHORIZES RELEASE FROM: (please be specific)

Sidney Health Center

Person/Agency/Facility Name

Address: _____

_____

Phone #: _____

DISCLOSE INFORMATION TO:

Dr. Michael Uphues, DO Caduceus Medical Partners, LLC

Person/Agency/Facility Name

Address: 724 Grand Avenue, Billings, MT 59101

Office Phone: 406-696-0409

Phone #: Fax: 406-929-2447

DESCRIPTION OF INFORMATION TO BE RELEASED (including date(s) of service):

Specify condition: _____

_____

PURPOSE OF DISCLOSURE:

☒ Continued health care ___ Patient request ___ Other: _____ (please specify)

EXPIRATION DATE: This authorization is good until 3 mo. from this date. If no date is specified, this authorization will expire 6 months from the date of signature unless withdrawn earlier in writing as explained below.

DISCLOSURES REQUIRING SPECIAL CONSENT (if applicable): My signature below specifically authorizes the release of health care information relating to the testing, diagnosis, or treatment for:

☐ HIV/AIDS Virus _____ ☐ Sexually Transmitted Diseases _____

☒ Mental Health/Psychiatric PTSD ☐ Drug, Alcohol Abuse/Treatment _____

~~~~~~

AUTHORIZATION: I authorize the release of information as described above. I understand that I may withdraw this authorization at any time. If I withdraw this authorization, I must do so in writing and present my written withdrawal to the Health Information Services (Medical Records) department at Sidney Health Center. My withdrawal will not apply to information that has already been released in response to this authorization. I understand that once the above information is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand that authorizing the use or disclosure of information identified above is voluntary. Sidney Health Center will not withhold treatment if I refuse to sign this authorization.

_____ _____

Signature of Patient or Legal Representative Date

If signed by legal representative, relationship to Patient is:

____ Parent of Minor ____ Guardian ____ Next of Kin ____ Health Care Power of Attorney

Original: SHC; Copy to patient *Completed by:* _____ *MR#:* _____
~~~~~~