Fax: 360-493-4543

Patient Name: _____ **Date of Birth**: ____/____/____

Mailing Address: _____

Phone: _____ **Previous Name** (If Applicable): _____

1ROI

I hereby request and authorize the following release of information (includes viewing):

Information to be released **BY**: Organization: _____
Phone: _____ Address: _____

Pick up or Mail

Information to be released **TO**: Organization: Dr Michael Uphues, DO
Phone: 406-696-0409 Address: 724 GRAND AVENUE, BILLINGS, MT 59101

INFORMATION TO BE RELEASED: ☒ All ☐ Date(s) or date range: LAST 2 YEARS OF SPECIFIED CONDITION(S)

☑ My health information relating the following condition or treatment: _____

☐ Billing Information ☐ Other: _____

INCLUDE the following information from my records released (please initial):
I understand that my records may contain information regarding the following sensitive diagnosis or treatment. If the item is initialed, then I give my specific authorization for these records to be released.

____ Drug/Alcohol abuse diagnosis/treatment ____ Sexually Transmitted Diseases
____ HIV/AIDS testing/diagnosis/treatment ____ Mental Illness/Psychiatric diagnosis/treatment

PURPOSE FOR DISCLOSURE:

☒ Patient's Request ☒ Continuing Care ☐ Legal ☐ Insurance ☐ Transfer of Care
☐ Other (explain): _____

This Release expires 90 days from the date signed or on the following date or when the following event occurs, whichever comes first:

Date: ____/____/____ OR Event: _____. ***Note:*** **An expiration date is not required if the recipient of the records is the patient or the patient's personal representative.**

MY RIGHTS

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form in order to take part in a research study OR to receive heath care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by PSPH based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. The form is available from PSPH Medical Records. OR
- Write a letter to Providence St Peter Hospital, Attention: Privacy Officer, 413 Lilly Road NE, Olympia, WA 98506

Once PSPH discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Signature: _____ **Date:** _____/_____/_____

If signature is of a personal representative of the patient, please complete the following:

Personal representative's name: _____ Relationship to patient: ☐ Parent ☐ Legal Guardian*
☐ Power of Attorney for Healthcare*
☐ Other*: _____

**Attach legal documentation if you are a personal representative other than parent*

For Official Use Only
Release of Information completed by:
Name: _____
Dept.: _____
Date: _____/_____/_____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION - ENGLISH

Form Number: 8707-11-NH-02 FCC: 5/14/09

White: To Chart **Yellow:** To Patient

Patient Identification:

Align Patient ID Here

Patient Name: _____ **Date of Birth**: ____/____/____

Mailing Address: _____

Phone: _____ **Previous Name** (If Applicable): _____

1ROI

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Pick up
or
Mail

INFORMATION TO BE RELEASED: ☐ All ☐ Date(s) or date range: _____

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