



Health Information Management- Release of Information
 P.O. Box 287, Harlowton, MT 59036
 Phone (406) 632-3154 FAX (406) 632-3175

**Authorization to Release
 Health Care Information From WMH**

Patient Name: _____ Date of Birth: ____/____/____
 Phone: (____) _____ Cell Phone: (____) _____

I request my protected health information (PHI) from: (please check all that apply)-

Bair Clinic Wheatland Memorial Healthcare

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

Releasing Records TO:

Name: _____ Phone: _____
 Address: _____ Fax: _____
 City: _____ State: _____ Zip: _____

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):

Hospital Medical Records Clinic Medical Records Immunization Records Pathology Reports
 X-Ray Reports Billing Records Radiology Disc Physical Therapy
 Laboratory All Medical Records Available
 Specific Date(s): _____ to _____ Provider's Name: _____
 Other _____

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

- Behavioral or Mental Health Issues Sexually Transmitted Diseases Sexual Assault Nurse Examiner Reports
- Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)
- 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 WMH's 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 WMH'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 WMH's 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.