DEER LODGE MEDICAL CENTER

1100 Hollenback Ln. Deer Lodge, MT 59722
Ph: 406-846-2212 Fax: 406-846-7708

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

Please submit this completed form to: Deer Lodge Medical Center, ATTN: Medical Records Department, 1100 Hollenback Ln., Deer Lodge, MT 59722, Telephone: (406) 846-2212, Fax: (406) 846-7708.

*__Form must be completed in its entirety. Incomplete form could delay response__.

Patient Information

Patient Name:	DOB:	Phone:
Address:	City:	State/Zip:

Purpose of Disclosure:

- ○ Personal Records
- ○ Transfer of Care/ Coordination of Care
- ○ Insurance
- ○ Referral
- ○ Legal
- ○ Other (specify):

Information to be released:

○ Entire Medical Record	○ History / Physical	○ Immunizations
○ ER Record	○ Lab/Pathology Reports	○ Billing Statement/Claims
○ Physician Clinic Record	○ Images	○ Other

EFFECTIVE: You may choose to provide an event (related to you or the purpose of the use/disclosure) upon which your authorization will expire. Otherwise, this authorization will expire twelve months after the date of signature.

Delivery Options: ○ Mail ○ Pick-Up ○ Fax (Healthcare Facilities Only)

Information to be released From:	Information to be released To:

I understand that:

**If releasing to a Third Party,
I acknowledge that the released information may contain alcohol, drug abuse, HIV, and mental health information. It is my intent that information released is prohibited for any other purpose than that which is stated above.

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 by giving written notice to the office listed above, but if I do, it will not have any effect on 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 subject to federal health information privacy laws (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 may be charged a $15.00 administrative fee, plus S.50/page, depending on the specifics of this request

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/ Patient Representative:	Date:
Print Name of Patient/Patient Representative:	Relationship or scope of your legal authority to act on the patient's behalf:

*supporting documentation may be required.