Southwest Montana Community Health Center
Keeping your whole family healthy

Authorization to Release Medical Information

Anaconda Office 110 Oak St. Anaconda, MT 59711
Telephone: (406) 563-0771
Fax: (406) 563-0774

PLEASE PRINT CLEARLY

Patient Name: _____ Birth Date: _____

Other Name (i.e. maiden name): _____

Address: _____ Phone: _____

- I authorize the Southwest Montana Community Health Center to _____ **RELEASE** copies of information from my medical record to:
- I authorize the Southwest Montana Community Health Center to _____ **RECEIVE** copies of my medical record from:
- I authorize the Southwest Montana Community Health Center to _____ **DISCUSS** my medical condition with:

Send to/Receive From: _____ Phone number: _____

Street Address: _____

City, State, & Zip Code: _____

The purpose of this release is for: _____ Diagnostic Evaluation _____ Transfer of Care

_____ Other (Please specify) _____

Records to be released:

____ Progress Notes ____ Lab Reports____ X-ray reports ____Medication Record ____ Physician Orders/Notes

____ Nursing Notes ____ Other (Please specify)_____

DATES OF SERVICE: FROM: _____ TO: _____

I understand that my records may be protected under Federal Confidentiality Regulations and cannot be disclosed without my signed consent unless as otherwise provided in the aforementioned regulations. I give special permission to release any information regarding **(check box and sign on line(s) below that you grant us permission to release the information to the above**).

_____**Substance Abuse** **Signature** _____

_____**Psychiatric/Mental Health** **Signature**_____

_____**HIV Status** **Signature**_____

_____**STD** **Signature** _____

- I understand that once this information is disclosed, the information is subject to re-disclosure and may no longer be protected by the Federal Privacy Regulations.
- I understand that I may revoke this consent—**IN WRITING**—at any time except to the extent that action has been taken in reliance thereon.
- Treatment will not be conditioned on refusing to sign this authorization.
- I understand that this office does not release records from other medical providers and that it is my responsibility to obtain records from other medical providers.
- I understand that this authorization will automatically expire 12 months from the date signed or earlier if revoked by me in writing.

SIGNED: _____ DATE: _____
(If signed by representative for patient, please indicate relationship)

WITNESS: _____ DATE: _____