Roosevelt Medical Center
PO Box 419
Culbertson, MT 59218
PH(406) 787-6401 FAX (406) 787-6473

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT:

_____ _____
Name of Patient/Any Previous Names **Date of Birth/Medical Record Number**

_____ _____
Mailing Address **City, State, Zip Code**

Authorizes: Release Protected Health Information To:

_____ _____
Name of Health Care Provider/Plan/Other **Name of Health Care Provider/Plan/Other**

_____ _____
Mailing Address **Mailing Address**

_____ _____
City, State, Zip Code **City, State, Zip Code**

INFORMATION TO BE RELEASED:

_____ **Medical History, Examination, Reports**
_____ **Immunizations**
_____ **Treatment or Tests**
_____ **X-Ray reports**
_____ **Allergy Records**
_____ **Prescriptions**
_____ **Consultations**

_____ **Surgical Reports**
_____ **Hospital Records Including Reports**
_____ **Laboratory Reports**
_____ **Entire Record**

_____ **Mental Health (Dates)** _____
_____ **Alcoholism (Date)** _____
_____ **HIV (AIDS) (Date)** _____
_____ **Drug Abuse (Date)** _____

_____ **Developmental Disablitities (Date)** _____
_____ **Sexually Transmitted Diseases (Date)** _____

_____ **Other (Specify)** _____

PURPOSE OF DISCLOSURE: (Check applicable categories)

_____ **Further Medical Care**
_____ **Personal**
_____ **Insurance Eligibility/Benefits**
_____ **Other (Specify)** _____

_____ **Legal Investigation or Action**
_____ **Changing Physicians**

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health care plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to be used or disclosed: I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Roosevelt Medical Centers Medical Records Department. ***RIGHT TO RECEIVE COPY OF THIS AUTHORIZATION*** **- I UNDERSTAND THAT IF I AGREE TOSIGN THIS AUTHROZIATION, WHICH I AM NOT REQUIRED TO DO, I MUST BE PROVIDED WITH A SIGNED COPY OF THIS FORM UPON REQUEST.** ***RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION*** **– I UNDERSTAND THAT I AM UNDER NO OLBIATION TO SIGN THIS FORM AND THAT THE PERSON(S) AND/OR ORGANIZATION(S) LISTED ABOVE WHO I AM AUTHORIZAING TO USE AND/OR DISCLOSE MY INFORMATION MAY NOT CONDITION TREATMENT, PAYMENT, ENROLLEMENT IN A HEALTH PLAN OR ELIGIBLITY FOR HEALTH BENEFITS ON MY DECISION TO SIGN THIS AUTHORIZATION.** ***RIGHT TO WITHDRAW THIS AUTHORIZATION*** **- I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact – Roosevelt Medical Center's Privacy Officer. I am aware that my withdrawal will not be effective as to uses/and or discloures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization.**

EXPIRATION DATE:

This authorization is good until the following date(s) _____or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wished:

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE:

_____ DATE:_____

(If signed by other than patient, state relationship and authority for signature

WITNESS _____