AUTHORIZATION FOR RELEASE OF INFORMATION

Butte Office: 445 Centennial Ave. Butte, MT 59701
Telephone: (406) 723-4075 (Medical Clinic)
(406) 496-6007 (Dental Clinic)
Main Fax: (406) 496-6037 Document Processing

PLEASE PRINT CLEARLY

Patient Name:_____ Birth Date:_____

Other Name (i.e. maiden name)_____

Address:_____ Phone: _____

PLEASE CHECK ONE BOX BELOW

- I authorize Blacktail Health to _____**RELEASE** copies of information from my medical record to _____
- I authorize Blacktail Health to _____**RECEIVE** copies of my medical record from:
- I authorize Blacktail Health to _____ **DISCUSS** my medical condition with:

SEND TO/RECEIVE FROM:_____**PHONE NUMBER:**_____

STREET ADDRESS: _____ **FAX:**_____

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 are 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 online(s) below that you grant us permission to release the information to the above).**

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

_____ **Reproductive 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.
- I can refuse to sign this authorization. I understand that my decision to sign or not to sign the form will have no effect on my eligibility for treatment, payment, or enrollment.
- I understand that any Reproductive Records will be protected from disclosure if the PHI is to investigate or impose liability on any person for the act of seeking, obtaining, providing, or facilitating reproductive health care, that is lawful under the circumstances in which it was provided, or to identify any person for such purposes.
- 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 a representative for patient, please indicate relationship)

WITNESS:_____ DATE:_____