BOZEMAN CLINIC P.L.L.P. 1245 North 15th Avenue, Bozeman, MT 59715, Ph:(406)587-4242, Fax:(406)587-3507

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

INSTRUCTIONS: Please submit this completed form to our office by fax or mail.

Patient Information:

Patient Name: (Last, First, Middle Initial, Other/Alias)	DOB:	Phone #:
Address:	City:	State/Zip:

Purpose of Disclosure:
- ☐ Transfer of Care
- ☐ Personal Records
- ☐ Legal
- ☐ Insurance
- ☐ Other (specify)_____

Information to be released (will send records from last 3 yrs unless otherwise specified):
- ☐ Specific Date(s) From:___/____/___ To:___/____/___
- ☐ All records

Please specify which records you would like included:

☐ Entire Medical Record	☐ Lab/Pathology Reports	☐ Immunizations
☐ Provider visit notes	☐ Radiology Reports/ X-rays	☐ Billing Statement/Claims

Information to be released FROM:	**Information to be released TO: (☐Self or☐ Third Party)**
Address:	Address:
Phone:	Phone:
Fax:	Fax:

Delivery Options:

☐ Mail	☐ Pick-up	☐ Fax (Healthcare Facilities only)

I acknowledge that the released information may contain alcohol, drug abuse, HIV, and/or mental health information. It is my intent that the information be released only for the purpose(s) stated above.

I understand that:

1) I may revoke this authorization at any time by giving written notice to this office, otherwise it will expire twelve months after the date of signature.
2) My treatment, payment, enrollment or eligibility for benefits is not contingent on signing this authorization.
3) Any disclosure of information carries the potential for re-disclosure if the requestor or receiver is not subject to federal privacy regulations
4) This office, its employees, and providers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
5) I may be charged a $15.00 administrative fee, plus up to $.50 per copied page.

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

Signature of Patient/ Patient Representative:	Date:
Printed Name of Patient/ Patient Representative:	Relationship to Patient (supporting documentation may be required):