AUTHORIZATION FOR DISCLOSURE OF HEALTHCARE INFORMATION

Patient Business Services
PO Box 6228
Helena, MT 59604

PHONE: (406) 447-2783
FAX: (406) 444-2193

Patient Name: _____ **Date of Birth:** _____ **SSN #:** _____

Phone: (H)_____ (W) _____

I hereby authorize staff of the Patient Business Services of St. Peter's Health to disclose protected health information about me to (provide the full name or other specific identification of the persons) or class of person(s) to whom disclosure may be made**:**

_____

Full Name and Title: (Individual we are releasing information to)

_____

Street Address Mailing Address

_____

City State Zip Phone Fax

THE INFORMATION TO BE RELEASED IS TO BE USED FOR THE PURPOSE OF:

❑ Attorney ❑ Personal ❑ At the request of the individual [1]
❑ Workers' Comp. ❑ Disability ❑ Other: _____

I REQUEST RELEASE OF THE FOLLOWING SPECIFIC INFORMATION FOR SPECIFIC DATE OF SERVICE:

❑ History & Physical ❑ Operative Report ❑ Xray ❑ Emergency
❑ Discharge Summary ❑ Physician Orders ❑ Lab ❑ Pathology
❑ Consultation ❑ Progress Notes ❑ Medications ❑ Entire Visit

☑ Authorization to Release Account/Finacial Information and to combine acounts to/from all accounts.

Specific Treatment Dates: _____

- Valid one year from signature date
- You have the right to revoke this authorization by doing so in writing and submitting your request to the Patient Business Services of St. Peter's Health. Your revocation will not apply to information that has already been disclosed in reliance on this authorization
- Authorizing the use or disclosure of information identified above is voluntary and I need not sign this form to obtain healthcare treatment.
- Once the information is disclosed, it may be subject to re-disclosure by the recipient and federal privacy laws or regulations may no longer protect the information.
- I release the above named facility from liability and claims of any nature pertaining to the disclosure of requested protected health information pursuant to this authorization.
- This authorization expires upon the occurrence of_____or on the following date _____(but not more than 12 months from the date of this authorization).

Signature: _____ **Date**:_____

(Circle One) **Patient** **Parent** **Spouse** **Guardian** **Personal Representative**

If patient is unable to consent give reason (minor, incompetent, etc)_____

[1] When the individual initiates the authorization and does not, or elects not to, provide a statement of purpose.