773-1067/06-10-19(Web)

ROI Pt

BOZEMAN HEALTH

Patient Label
Name:_____
DOB:_____
M#:_____

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

INSTRUCTIONS: Please submit this completed form to: Bozeman Health Deaconess Hospital, ATTN: Medical Record Department, 915 Highland Boulevard, Bozeman, MT 59715, Telephone: (406) 414-1055, Fax: (406) 414-1069. Email: medrecords@bozemanhealth.org

*Form must be completed in its entirety. Incomplete form could delay response.

## Patient Information:

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

**Purpose of Disclosure:**

☐ Transfer of Care ☐ Referral ☐ Personal Records ☐ Legal ☐ Insurance

☐ Other (specify): _____

**Information to be released:** ☐ Specific Date(s) From: _____ To: _____

☐ All past, present and future encounters/visits

| | | |
|---|---|---|
| ☐ Entire Medical Record | ☐ ER Record | ☐ Discharge Summary |
| ☐ Pertinent Only (Provider notes & test results) | ☐ History / Physical | ☐ Operative Reports |
| ☐ Billing Statement/Claim | ☐ Immunizations | ☐ Rehabilitation Services |
| ☐ Consultations | ☐ Lab/Pathology Reports | ☐ Home Oxygen |
| ☐ Physician Clinic Record (Provider Names) _____ _____ _____ | Hospital Radiology: ☐ Entire Record ☐ Images ☐ Report Only<br>Advanced Medical Imaging (AMI): ☐ Entire Record ☐ Images ☐ Report Only | ☐ Other:_____ |

**Delivery Options:** ☐ Secure (encrypted) Email (List): _____

☐ Mail ☐ Pick-Up ☐ Fax (Healthcare Facilities Only) ☐ My Chart (Epic Only)

EFFECTIVE: You may choose to provide an event (related to you or the purpose of the use/disclosure) upon which your authorization will expire. Otherwise, this authorization will expire twelve months after the date of signature.

Event: _____

## Information to be released From:

☐ Bozeman Health Deaconess Hospital & Clinics
☐ Big Sky Medical Center & Clinics
☐ Bozeman Health Urgent Care
☐ Convenience Care

_____
_____

Phone:_____
Fax: _____

## Information to be released To:

☐ Self (patient) or ☐ Third Party**

_____
_____
_____

Phone:_____
Fax: _____

** If releasing to a Third Party,
I acknowledge that the released information may contain alcohol, drug abuse, HIV, and mental health information. It is my intent that information released is prohibited for any other purpose than that which is stated above.

I understand that:

1. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
2. I may revoke this authorization at any time by giving written notice to the office listed above, but if I do, it will not have any effect on actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requestor or receiver is not subject to federal health information privacy laws (not a health plan or health care provider), the released information may no longer be protected by federal privacy regulations and may be redisclosed.
4. I may be charged a $15.00 administrative fee, plus $.50/page, depending on the specifics of this request

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

| Signature of Patient/ Patient Representative: | Date: |
|---|---|
| Print Name of Patient/ Patient Representative: | * Relationship or scope of your legal authority to act on the patient's behalf: |

*Supporting documentation may be required.