Clark Fork Valley Hospital
& Family Medicine Network

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Clark Fork Valley Hospital	Plains Family Medicine	Thompson Falls Family Medicine	Hot Springs Family Medicine
PO Box 768 Plains, MT 59859 Ph: (406) 826-4860 Fax: (406) 826-4828	PO Box 768 Plains, MT 59859 Ph: (406) 826-4810 Fax: (406) 826-4803	PO Box 459 Thompson Falls, MT 59873 Ph: (406) 827-4442 Fax: (406) 827-4006	PO Box 72 Hot Springs, MT 59845 Ph: (406) 741-3602 Fax: (406) 741-3603

I, _____ _____
(Print patient name) *(Date of birth and/or SS #)*

Herby authorize: _____ _____
(Name of hospital/facility) *(City, state and zip code)*

▼ **Must be completed**

To provide to: _____
(Name of person/facility)

_____ _____
(Mailing address, city, state) *(Phone number)*

Purpose: ☐ Transfer of care ☐ Self ☐ Legal ☐ Other: _____

Covering the period(s) of healthcare: From (date) _____ to (date) _____

Information to be disclosed *(please check all that apply)* : **Information may include records from other sources*

☐ Diagnosis ☐ Medications ☐ Allergies ☐ Immunization records ☐ Lab reports ☐ Radiology reports

☐ Photographs/digital images ☐ Physician or consultation reports ☐ All Medical Records

☐ Other *(please describe)* : _____

☐ Discuss care with *(person/persons)* : _____

- I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) and/or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and/or drug abuse.
- I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire six months from the date of signing. If this authorization is for research, the authorization will expire at the end of the research study.
- Clark Fork Valley Hospital, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality regulations and guidelines. If I have questions about disclosing my health information, I can contact the Health Information Management department – (406) 826-4861.
- I understand authorizing the use or disclosure of the information identified above is voluntary.
- **I do not need to sign this form to ensure healthcare treatment.**

_____ _____
(Signature of patient or legal representative) *(Date)*

Printed name of patient's legal medical representative: _____

If signed by legal representative, indicate relationship to patient: _____

** Attach legal documentation if you are the legal guardian or have Power of Attorney for Healthcare*

_____ _____
(Signature of witness) *(Date)*

☐ Picture ID verified ☐ Copy of ID attached MR # : _____