Bitterroot Health Daly Hospital
1200 Westwood Drive
Hamilton, Montana 59840
(406) 363-2211
www.bitterroothealth.org

Patient Name: _____

MRN/FIN:_____

Authorization for Disclosure of Health Information

☐ I hereby authorize _____ Phone: _____ Fax: _____
to disclose to **Bitterroot Health Daly Hospital and/or its associated clinics** the following information from the health records of:

☐ I hereby authorize **Bitterroot Health Daly Hospital and/or its associated clinics** to disclose the following information from the health records of:

Patient Name: _____ Date of Birth: _____
First Middle Last Month Day Year
Street Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

1. This information is to be disclosed to: ☐ Self or ☐ Name: _____
Address: _____
_____
Phone: (_____)_____ Fax: (_____)_____

2. Purpose of Disclosure:
☐ Patient Request ☐ Continuing Care ☐ Other: _____

3. Covering the periods of healthcare: From: _____ To: _____

4. Information to be disclosed:
☐ **Past 2 Years:** Highlights (Clinic Notes, H&Ps, Discharge Summaries, Lab Results, Radiology Reports, etc.
☐ **ALL:** Mammography + Endoscopy + Immunizations

☐ Discharge Summary	☐ Emergency Room Records	☐ PT/OT/Speech Therapy Notes
☐ History & Physical Examination	☐ Radiology Reports	☐ Home Health/Hospice Records
☐ Consultation Reports	☐ Radiology Images on CD	☐ Physician's Orders
☐ Operative Notes	☐ Cardiology Tests	☐ Complete Health Record
☐ Progress Notes	☐ Laboratory/Pathology Results	☐ Office/Clinic Notes

☐ Other (please specify): _____

5. Method of delivery:
☐ Walk-in ☐ Fax ☐ Mail ☐ Email: I understand email is not a secure method for releasing my health records. I still wish to use this as my preferred method. Email address: _____

6. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

7. I understand 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 (6) months from the date of signing.**

8. The facility, 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.

9. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management (HIM) Department Head or the Privacy Officer of Bitterroot Health Daly Hospital.

10. I understand authorizing the use or disclosure of the information above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____
Signature of Patient or Legal Representative Date
If signed by Legal Representative, indicate relationship to the patient: _____

For Office Use Only:

Report Request ID#:
_____ _____ _____
_____ _____ _____

Number of Pages Released: _____
Date Completed: _____
Released by: _____