BOZEMAN CREEK family health

316 EAST BABCOCK · BOZEMAN, MONTANA 59715
PH: 406.585.0022 · FX: 406.585.0032

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT'S FULL NAME: _____ **BIRTHDATE:** _____
ADDRESS: _____
TELEPHONE #: _____ **SS#:** _____
PREVIOUS NAME: _____

☐ **REQUEST RECORDS FROM:**
NAME: _____ **TELEPHONE #**_____
ADDRESS: _____
_____

☐ **SEND RECORDS TO:**
NAME_____ **TELEPHONE#:** _____
ADDRESS: _____
C/O Doctor_____

Reason for Medical Records Transfer: Moving/Changing location_____, Billing/Insurance issues_____, Scheduling/Provider Availability _____, Patient Care/ Medical treatment _____, Other, please explain:_____

INFORMATION REQUESTED

THIS INFORMATION IS NEEDED FOR THE PURPOSE OF: _____
FROM (DATE OF SERVICE): _____ **TO (DATE OF SERVICE):**_____

□ **Chart Notes** □ **Consultations**
□ **Hospital Records** □ **Immunizations**
□ **Lab Results** □ **Entire Chart**
□ **Radiology Reports** □ **Other**_____
□ **Prior Records *specify doctor**_____
***Records may not be complete/ please initial**_____

- I understand that any and all information regarding testing, diagnosis and/or treatment for human immunodeficiency virus (HIV AIDS Virus), acquired immunodeficiency syndrome (AIDS), sexually transmitted diseases, psychiatric disorders/mental health, and alcoholism and/or drug abuse will be included with the records released pursuant to the above request. I understand that this information is protected by Federal Law and cannot be released without this consent. You specifically have my permission to release this information if such a part of my record.
- I understand that I have the right to revoke this authorization in writing at any time and present it to the Bozeman Creek Family Health Medical Records Department. This will not have any affect on actions/disclosure made prior to receiving the revocation.
- I understand that when my information is used or disclosed pursuant to this authorization, this disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules (unless this information is protected by 42 CFR for alcohol/drug abuse records).
- There may be a fee for this service which is permissible by Montana Code annotated 50-60-540. I understand that it may be necessary for me to make payment in advance of receiving my records. Bozeman Creek will provide one complete copy free of charge for patients to use for their personal records. Any additional copies will be subject to a copy fee.
- 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.

If records are over 60 pages please mail to BCFH mailing address instead of faxing.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN: _____

DATE: _____ **EXPLANATION IF SIGNED BY OTHER THAN PATIENT:** _____

EXPIRATION OF AUTHORIZATION EXPIRES ONE YEAR FROM DATE ABOVE: _____**INITIAL**