Authorization to Obtain or Disclose Protected Health Information

Patient Name	Date of Birth	Last 4 of Social Security Number
Address	**City, State, Zip Code**	**Telephone Number**

I hereby authorize Mountain View Family Health Care, PC to release or obtain the Protected Health Information specified in this request to or from the provider, organization, agency or person named.

Obtain from: MOUNTAIN VIEW FAMILY HEALTH CARE, PC
2619 Colonial Drive, Ste A
Helena, MT 59601-4948

Telephone: 406-442-1231 FAX: 406-442-8201

Release To: _____
Organization, Facility, Agency, Individual

_____
Address

_____
City, State, Zip Code

Purpose: ☐ Further Medical Care ☐ Workers' Comp ☐ Personal Use ☐ Insurance ☐ Legal

☐ Other_____

Pertinent Protected Health Information Allowed to be Released:

☐ Current Medical Record (**Last 3 years**) ☐ Labs ☐ Radiology ☐ Progress Notes ☐ Medication Records

☐ Psychiatric Health Records ☐ Other (specify):_____

Acknowledgement:

- I understand that this form is voluntary and I need not sign this to obtain medical healthcare treatment.
- I understand that Mountain View Family Health Care, PC will not release other provider/facility medical records and that those records will need to be obtained from said provider or facility.
- I understand 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 understand that the information to be disclosed may include any or all information involving communicable/venereal disease, psychological or psychiatric conditions, drug or alcohol abuse and/or alcoholism unless asked to have it redacted. It may also include, but is not limited to, disease such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses (HIV), also known as acquired immune deficiency syndrome (AIDS).
- I release the above named facility from liability and claims of any nature pertaining to the disclosure of the requested protected health care information pursuant to this authorization.
- I understand that I have the right to revoke this authorization by doing so in writing and submitting your request directly to this facility. The revocation will not apply to information previously released.

This authorization expires on the following date:_____but not more than six months from the date signed.

Signature:_____ **Date:**_____
Patient (Parent or Legal Guardian)

Relationship (if other than patient):_____ ☐ Power of Attorney

Name of individual signing on behalf of patient:_____

Verification: ☐ Driver's License # _____ ☐ Other Appropriate ID:_____