Hospital HIM Department
600 MT Highway 91 South
Dillon, MT 59725
Phone: (406) 683-3073
Fax: (406) 683-3076

Barrett Hospital & HealthCare provides compassionate care, healing, and health-improving service to all community members throughout life's journey.

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Turn around for completed Release of Information is 10 days.

Patient's Name: ____/____________________Date of Birth:____/____/____
First Name *(Middle Initial)* *Last Name* *Maiden or Other Name*

Phone: ____________________________ Cell: ________________________________ Last 4 Digits of SSN:_____________

I authorize BARRETT HOSPITAL & HEALTHCARE to
☐ RECEIVE from: / ☐ RELEASE to:

Name of Individual(s) and/or Agency:
____

Address: ____
Street Address *City* *State* *Zip*

Phone: ___________________________ Fax: ____________________________________

Purpose: *(circle one)* **Personal Use Continued Care Transfer Care to:__________________**
Other:_________________

Initial	Information to be Released	Date Range of Service	Format *(circle one)*
	Lab Reports:	___________ to ___________	**Paper** *or*
	Notes:	___________ to ___________	**Electronic**
	Imaging: (CT, MRI,X-Ray, US, Mammo) Reports Disc	___________ to ___________	**Delivery** *(circle one)*
	Pathology Reports:	___________ to ___________	**Pick up**
	All Records (excluding mental health/substance abuse)	___________ to ___________	**Fax**
	Other: (describe)	___________ to ___________	**Mail**
	Mental Health/Substance Abuse Treatment Records	___________ to ___________	**Other**

42 CFR PART 2 PROHIBITS UNAUTHORIZED DISCLOSURE OF THESE RECORDS.
I understand and acknowledge that this authorization extends to all or any part of the information designated above, which may include treatment for physical and mental illness, and/or alcohol/drug abuse and/or AIDS (Acquired Immunodeficiency Syndrome), and/or the results of an HIV test. I expressly consent to the release of the information designated above.

I understand that this authorization is valid for one (1) year, unless revoked by my written notice to Barrett Hospital & HealthCare, provided said notice is received prior to release of the above-designated information.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered under the federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.

If requestor is a party other than the patient or patient's personal representative:
I understand that ___________________________ will receive compensation for its use/disclosure of the information.
I understand that I may refuse this authorization and that my refusal to sign may affect my ability to obtain treatment or payment or my eligibility for benefits.
I understand that I may inspect or copy any information used/disclosed under this authorization.

____ ____________________
Signature of Patient or Personal Representative **Date**

If Patient is unable to sign: ______________________________________ ___________________________
Printed Name of Personal Representative Relationship to Patient

*Reason Patient is Unable to Sign:*____ ☐ *Patient is a minor*