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

BARRETT HOSPITAL & HEALTHCARE

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. We DO NOT email records.

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* **Electronic**
	Notes:	_____ to _____	
	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 _____	**Push Images**

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*