



# Clark Fork Valley Hospital & Family Medicine Network

## AUTHORIZATION FOR RELEASE OF INFORMATION

### **Section A: Must be completed for all authorizations**

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

**Patient Name:** \_\_\_\_\_

**Health Record Number:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Persons/organizations providing the information:** \_\_\_\_\_ **Persons/organizations receiving the information:** \_\_\_\_\_

- |  |       |
|--|-------|
| <input type="checkbox"/> Clark Fork Valley Hospital _____  | _____ |
| <input type="checkbox"/> Family Medicine Network _____   | _____ |
| <input type="checkbox"/> Plains <input type="checkbox"/> Thompson Falls <input type="checkbox"/> Hot Springs <input type="checkbox"/> Bull River |       |
| <input type="checkbox"/> _____   | _____ |
| <input type="checkbox"/> _____   | _____ |
| <input type="checkbox"/> _____   | _____ |

**The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated) (please include dates) (\*\*Information may include records from other sources\*\*)**

- |   |  |
|---|--|
| <input type="checkbox"/> problem list _____   | <input type="checkbox"/> medication list _____               |
| <input type="checkbox"/> list of allergies _____  | <input type="checkbox"/> immunization records _____          |
| <input type="checkbox"/> most recent history _____  | <input type="checkbox"/> most recent discharge summary _____ |
| <input type="checkbox"/> lab results (please describe the dates or types of lab tests you would like disclosed): _____                      |  |
| <input type="checkbox"/> x-ray and imaging reports (please describe the dates or types of x-rays or images you would like disclosed): _____ |  |
| _____   |  |
| <input type="checkbox"/> Consultation reports from (please supply doctors' names): _____  |  |
| _____   |  |
| <input type="checkbox"/> other (please describe): _____   |  |
| _____   |  |
| <input type="checkbox"/> Entire record  |  |

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.

[Please complete Sections B & C on reverse side]

**Section B: Must be completed only if a health plan or a health care provider has requested the authorization:**

1. The health plan or health care provider must complete the following:
  - a. What is the purpose of the use or disclosure? \_\_\_\_\_
  - b. Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes \_\_\_\_\_ No \_\_\_\_\_
2. The patient or the patient's legal medical representative must read and initial the following statements:
  - a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. Initials: \_\_\_\_\_
  - b. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. Initials: \_\_\_\_\_

**Section C: Must be completed for all authorizations:**

The patient or the patient's legal medical representative must read and initial the following statements:

1. I understand that this authorization will expire on \_\_\_/\_\_\_/\_\_\_ (DD/MM/YY) Initials: \_\_\_\_\_
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on my actions they took before they received the revocation. Initials: \_\_\_\_\_

\_\_\_\_\_  
Signature of patient or patient's legal medical representative  
(Form must be completed before signing.)

\_\_\_\_\_  
Date

Picture ID verified     Copy of ID attached

Printed name of patient's legal medical representative: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Signature of witness \_\_\_\_\_ Date \_\_\_\_\_

- **YOU MAY REFUSE TO SIGN THIS AUTHORIZATION \***
- **MUST BE NOTARIZED WHEN MAILING OR FAXING BACK**

**\*\*This authorization will expire twelve (12) months from date of signing, unless the patient/legal representative designates a shorter time frame. \*\***

Distribution of copies:                      Original to provider;                      Copy to patient                      Copy to accompany use or disclosure