



Clark Fork Valley Hospital & Family Medicine Network

10 KRUGER ROAD . PO BOX 768 . PLAINS, MT 59859 . (406) 826-4800 . WWW.CFVH.ORG

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Health Information Management Department	Phone: (406) 826-4861	Fax: (406) 826-4828
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I, _____
 (Print patient name) _____
 Date of birth and/or SS #)

Herby authorize: _____
 (Name of hospital/facility) _____
 (City, state and zip code)

▼ Must be completed

To provide to: _____
 (Name of person/facility)

 (Mailing address, city, state) _____
 (Phone number)

Purpose: Transfer of care Self Legal Other: _____

Covering the period(s) of healthcare: From (date) _____ to (date) _____

Information to be disclosed (please check all that apply) : *Information may include records from other sources

Diagnosis Medications Allergies Immunization records Lab reports Radiology reports

Photographs/digital images Physician or consultation reports

Other (please describe) : _____

Discuss care with (person/persons) : _____

- ▶ I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) and/or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and/or drug abuse.
- ▶ I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire six months from the date of signing. If this authorization is for research, the authorization will expire at the end of the research study.
- ▶ Clark Fork Valley Hospital, 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. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality regulations and guidelines. If I have questions about disclosing my health information, I can contact the Health Information Management department – (406) 826-4861 or Clark Fork Valley Hospital's Privacy Officer – (406) 826-4816.
- ▶ I understand authorizing the use or disclosure of the information identified above is voluntary.
- ▶ **I do not need to sign this form to ensure healthcare treatment.**

 (Signature of patient or legal representative) _____
 (Date)

Printed name of patient's legal medical representative: _____

If signed by legal representative, indicate relationship to patient: _____

* Attach legal documentation if you are the legal guardian or have Power of Attorney for Healthcare

 (Signature of witness) _____
 (Date)

Picture ID verified Copy of ID attached MR # : _____