

**AUTHORIZATION FOR DISCLOSURE OF
HEALTHCARE INFORMATION**



Patient Business Services
PO Box 6228
Helena, MT 59604

PHONE: (406) 447-2800
FAX: (406) 444-2193

Patient Name: _____ Date of Birth: _____ SSN #: _____

Phone: (H) _____ (W) _____

I hereby authorize staff of the Patient Business Services of St. Peter's Health to disclose protected health information about me to (provide the full name or other specific identification of the persons) or class of person(s) to whom disclosure may be made:

Full Name and Title: (Individual we are releasing information to)

Street Address

Mailing Address

City

State

Zip

Phone

Fax

THE INFORMATION TO BE RELEASED IS TO BE USED FOR THE PURPOSE OF:

- Attorney Personal At the request of the individual ¹
 Workers' Comp. Disability Other: _____

I REQUEST RELEASE OF THE FOLLOWING SPECIFIC INFORMATION FOR SPECIFIC DATE OF SERVICE:

- History & Physical Operative Report Xray Emergency
 Discharge Summary Physician Orders Lab Pathology
 Consultation Progress Notes Medications Entire Visit

Authorization to Release Account/Financial Information and to combine accounts to/from all accounts.

Specific Treatment Dates: _____

- Valid one year from signature date
- You have the right to revoke this authorization by doing so in writing and submitting your request to the Patient Business Services of St. Peter's Health. Your revocation will not apply to information that has already been disclosed in reliance on this authorization
- Authorizing the use or disclosure of information identified above is voluntary and I need not sign this form to obtain healthcare treatment.
- 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 release the above named facility from liability and claims of any nature pertaining to the disclosure of requested protected health information pursuant to this authorization.
- This authorization expires upon the occurrence of _____ or on the following date _____ (but not more than 12 months from the date of this authorization).

Signature: _____ **Date:** _____

(Circle One) Patient Parent Spouse Guardian Personal Representative

If patient is unable to consent give reason (minor, incompetent, etc) _____

¹ When the individual initiates the authorization and does not, or elects not to, provide a statement of purpose.