# AUTHORIZATION TO DISCLOSE PATIENT HEALTH INFORMATION

PUREVIEW Health Center
**1930 9th Avenue – Helena, MT 59601**
Phone: (406) 500-2092 Fax: (406) 500-2128

Patient Name, AKAs:_____Date of Birth: ____/____/____Phone:_____
Address:_____

I authorize PureView Health Center to: ___ RELEASE ___ RECEIVE ___ DISCUSS my medical record to/from:

RELEASE TO/RECEIVE FROM:_____PHONE:_____FAX:_____

ADDRESS:_____CITY:_____STATE:_____

**Purpose of Release:**

___Continuity of Care ___Insurance (Payments/Claims) ___Legal ___Personal Use/Review

___Transfer of Care (Transferring care from PVHC. *Please close my chart*.)___Other (Please Specify):_____

Covering a time period from: ____/____/____ to____/____/____ (If time frame is not specified most recent 3 visit notes will be provided.)

**Information to be Released/Received:**

___Clinic Notes ___Laboratory Tests ___Pathology Reports ___Billing ___Medication Records ___Imaging Reports
___Dental Images ___Consultation Reports ___Immunization/Allergy Records ___Other: (please specify)_____

**The below records will be released unless checked:**

___Alcohol and Drug Info/Treatment ____Psychiatric/Behavioral Health ___AIDS/HIV/STD Testing and Results

- This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here:____/____/____
- This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation. PureView Health Center Notice of Privacy Practice describes how to cancel (revoke) this authorization.
- PureView Health Center will not restrict my treatment if I choose not to sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- PureView Health Center cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release PureView Health Center from any and all liability resulting from a redisclosure by the recipient.
- **Confidentiality of Alcohol and Drug Abuse Patient Records**: Any records disclosed by PureView pursuant to your consent granted by this ROI will contain a notice to the receiving party about further disclosure of the records in one of the following formats: 1) *This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFRT part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)5 and 2.65;* OR 2) *42 CFR part 2 prohibits unauthorized disclosure of these records.*

Your signature indicates that you have read and understand this form and authorize release of your information as described above.

**Patient/Authorized Representative Signature***: _____**Date:** _____

*If signed by a patient's authorized representative, supporting documentation must accompany this authorization form.

Witness signature: _____Date: _____

***This Authorization is not valid and will not be fulfilled unless *all* highlighted fields are completed. ***