# Ruby Valley Medical Center

Staff Use Only

Initials:_____

Date:_____Time:_____

Method_____

**INSTRUCTION:**

**PATIENT IDENTIFICATION**

**Make sure all blank lines are filled in. Failure to do so could prevent or delay processing.**

Name (Legal/Maiden/Other):_____

Address:_____

City: _____ State: _____ Zip: _____ Phone #: _____

Date of Birth: _____ Social Security Number (optional): _____

**PROVIDER / ORGANIZATION**
(Who is authorized to release the information.)

Provider Name: Ruby Valley Medical Center

Address: 321 Madison Street, Po Box 336

City: Sheridan State: MT Zip: 59749

Phone: 406-842-5453 Fax: 406-842-5455

**REQUESTOR:**
(Where do you want the information sent)
Please indicate your primary physician

Requestor Name: _____Primary Physician:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

**INFORMATION REQUESTED:**
*Charges may apply*

Service Dates: _____

☐ Abstract (all provider dictations/test results) ☐ Lab/Radiology Results ☐ Entire Record

☐ Other, please specify: _____

**PURPOSE OF RELEASE:**

**(Check all that apply)**

☐ Transfer of Care ☐ Continuing Care ☐ Insurance Coverage ☐ SSA/Disability ☐ Personal Use

☐ Other: _____

**SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW**

I authorize the release of the information listed below which requires specific consent under federal law: **(Initial all that apply)**
**(Note: Depending on what is initialed, we may be unable to fulfill this authorization.)**

_____ Substance Abuse _____ Mental Health Treatment (excluding psychotherapy notes) _____ HIV/AIDS related testing

Signature of Patient or
Authorized Representative: X _____ Relationship:_____

Witness Signature: X _____

**This authorization is effective for _____ months but no longer than 1 year from the date on which it was signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the Medical Records Department of the source facility. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under conditions established by the source facility. I understand that my health care and payment for my health care will not be affected if I do not sign this form. I understand this authorization is voluntary. I understand that if the recipient of this information is not a health plan or provider, the released information may no longer be protected by federal privacy regulations and may be subject to re-disclosure. I understand that I am entitled to receive a copy of this completed authorization form.**

Prohibition of re-disclosure: This form does not authorize re-disclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, and HIV/AIDS test results, federal requirements (43 CFR Part2) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may result from unauthorized disclosure of alcohol/drug abuse, mental health or HIV/AIDS related testing and or treatment.

_____

Signature of Patient or Authorized Representative

_____

Print Name/Relationship to Patient

_____

Date