AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Ruby Valley Medical Center/ 321 Madison Street, PO Box 336/ Sheridan, MT 59749
Phone: 406-842-5453 Fax: 406-842-5455

Patient's Name: _____

Date of Birth: _____**Phone:**_____

Address:_____

I AUTHORIZE RUBY VALLEY MEDICAL CENTER TO (circle one)

RECEIVE from / RELEASE to:

Organization:_____

Address:_____

Phone:_____ Fax:_____

Reason for Disclosure: (circle one) Personal Use Continued Care Transfer Care

Provider:_____ **Other reason:**_____

Initial	Information to be Released	Start Date	End Date
	Lab Reports		
	Notes		
	Imaging: (CT, MRI, X-Ray, US etc.		
	All Records		
	Other: (describe)		
	Mental Health -see other form		
	Substance Abuse		

Format (circle one): Paper Fax Mail Pick up

Other:_____

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 Date

_____ _____

Printed Name of Representative Relationship to Patient