



Ruby Valley Medical Center

Staff Use Only

Initials: _____

Date: _____ Time: _____

Method: _____

INSTRUCTION:	Make sure all blank lines are filled in. Failure to do so could prevent or delay processing.
PATIENT IDENTIFICATION	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: _____
	Address: _____
	City: _____ State: _____ Zip: _____
	Phone: _____ Fax: _____

REQUESTOR: (Where do you want the information sent) Please Indicate your Primary Physician	Requestor Name: <u>Ruby Valley Medical Center</u> Primary Physician: _____
	Address: <u>321 Madison Street, Po. Box 336</u>
	City: <u>Sheridan</u> State: <u>MT</u> Zip: <u>59749</u>
	Phone: <u>406-842-5453</u> Fax: <u>406-842-5455</u>

INFORMATION REQUESTED: <i>Charges may apply</i>	Service Dates: _____
	<input type="checkbox"/> Abstract (all provider dictations/test results) <input type="checkbox"/> Lab/Radiology Results <input type="checkbox"/> Entire Record <input type="checkbox"/> Other, please specify: _____

PURPOSE OF RELEASE:	(Check all that apply)
	<input type="checkbox"/> Transfer of Care <input type="checkbox"/> Continuing Care <input type="checkbox"/> Insurance Coverage <input type="checkbox"/> SSA/Disability <input type="checkbox"/> Personal Use <input type="checkbox"/> 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