AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

❑ **St. Peter's Health Regional Medical Center**
Medical Records Department
2475 Broadway
Helena, MT 59601
Phone: (406) 444-2178
Fax: (406) 447-2627

❑ **St. Peter's Health Medical Group~Broadway**
Medical Records Department
2550 Broadway
Helena, MT 59601
Phone: (406) 495-6882 ***or***
(406) 495-6883
Fax: (406) 495-6885

❑ **St. Peter's Health Medical Group~North**
Medical Records Department
3330 Ptarmigan Lane
Helena, MT 59602
Phone: (406) 495-7967
Fax: (406) 495-7969

❑ **St. Peter's Health Medical Group~Townsend**
Medical Records Department
515 S. Front St.
Townsend, MT 59644
Phone: (406) 444-8200
Fax: (406) 444-8291

Patient Name:_____ Date of Birth:_____

SSN:_____ Phone:_____

To receive information about me from:

FROM:_____
Hospital, Agency, Physician, etc.

_____
Address.

_____

_____
Phone/Fax

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

Send TO:_____
Hospital, Agency, Physician, etc.

_____
Address

_____

_____
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 the release of the following specific information for specific dates of service:

❑ Health Summary ❑ Pathology Report ❑ Entire Visit Date:_____
❑ History & Physical ❑ Operative Report ❑ Entire Record
❑ Office/Progress Note ❑ Discharge Summary ❑ Immunization
❑ Consult ❑ Physician Order ❑ Other:_____
❑ X-ray ❑ Emergency Services
❑ Laboratory Report ❑ Medication Sheet

Specific Treatment Dates:_____

Terms and Conditions of Release:

- You have the right to revoke this authorization by doing so in writing and submitting your request to the Medical Records Department 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 of 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 occurrence of _____or on the following date _____(but not more than 12 months from the date of this authorization).

Signature: _____ **Date:**_____

Relation to Patient: ❑ Parent ❑ Guardian ❑ Spouse ❑ Personal Representative ❑ ID Verified_____

(1) If a patient is unable to give consent, provide a reason:_____