

AUTHORIZATION TO DISCLOSE PRIVATE HEALTH CARE INFORMATION

Name of Patient: _____ **Phone:** _____ **Date of Birth:** _____

I authorize: Billings Clinic
 Other organization _____
(Name and address of individual or organization that may disclose your protected health information)

To **discuss** my protected health information To **release** my protected health information

To use and/or disclose my private health care information as described below to:

Name: _____
(Name of person, class of persons, or organization to whom your protected health information may be disclosed)
Address: _____
City: _____ State: _____ Zip: _____

Please indicate the location where you received the services you wish disclosed: (Please check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Billings Clinic | <input type="checkbox"/> Bozeman OB/Gyn Clinic |
| <input type="checkbox"/> Billings Clinic Hospital | <input type="checkbox"/> Cody Clinic |
| <input type="checkbox"/> Behavioral Health Clinic | <input type="checkbox"/> Columbus Clinic |
| <input type="checkbox"/> Billings Clinic Psychiatric Center | <input type="checkbox"/> Miles City Clinic |
| <input type="checkbox"/> Aspen Meadows | <input type="checkbox"/> Red Lodge Clinic (Prior to November 18, 2010) |

Records for the following: (indicate one that applies)

Date(s) of service or period of time _____
Doctor _____
Type of treatment _____

The type and amount of information to be used or disclosed is as follows: (please check those that apply)

- | | |
|---|--|
| <input type="checkbox"/> Hospital Medical Records | <input type="checkbox"/> Psychiatric Database |
| <input type="checkbox"/> Clinic Medical Records | <input type="checkbox"/> Alcohol/Drug Record |
| <input type="checkbox"/> Pertinent Information | <input type="checkbox"/> HIV Test Results |
| <input type="checkbox"/> Immunization Record | <input type="checkbox"/> Psychological Report |
| <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Billing Record |
| <input type="checkbox"/> X-Ray films/reports | <input type="checkbox"/> Outpatient Pharmacy Records |

I authorize the release of information in my health record which may include information relating to:

- sexually transmitted disease
- acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV)
- behavioral or mental health services
- treatment for alcohol and drug abuse which is protected by virtue of the provisions of Federal Regulations 42 CFR, part 2.

