



201 Yellowstone Ave.
Cody, WY 82414

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)

- Billings Clinic
- Billings Clinic Hospital
- Behavioral Health Clinic
- Billings Clinic Psychiatric Center
- Aspen Meadows
- Bozeman OB/Gyn Clinic
- Cody Clinic
- Columbus Clinic
- Miles City Clinic
- 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)

- Hospital Medical Records
- Clinic Medical Records
- Pertinent Information
- Immunization Record
- Pathology Report
- X-Ray films/reports
- Psychiatric Database
- Alcohol/Drug Record
- HIV Test Results
- Psychological Report
- Billing Record
- 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.

