



407 N. A Street  
Columbus, MT 59019

### 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                    | Bozeman OB/Gyn Clinic |
| Billings Clinic Hospital           | Cody Clinic           |
| Behavioral Health Clinic           | Columbus Clinic       |
| Billings Clinic Psychiatric Center | Miles City Clinic     |
| Aspen Meadows                      | Red Lodge Clinic      |

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

**This information is needed for the purpose of:**

At the request of the patient

Other \_\_\_\_\_

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the authorization is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes providing treatment services in reliance on a valid consent to disclose information to a third party payer. Additional information regarding the individual's right to revoke an authorization is found in Billings Clinic's notice of privacy practices.

**Unless otherwise revoked, this authorization will expire on the following date, event, or condition:**

3 months

1 year

Event/Other \_\_\_\_\_

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive treatment, payment for services, enrollment or eligibility for benefits from Billings Clinic. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524.

**I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules (unless the information is protected by 42 U.S.C Sec 290dd-2 for alcohol/drug abuse records).**

If I have questions about disclosure of my health information, I can contact the Billings Clinic Health Information Management Department.

\_\_\_\_\_  
**Signature of Patient or Legal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
If signed by Legal representative, Relationship to Patient

\_\_\_\_\_  
Witness