Mineral Community Hospital Clinic

Health Care for Your Family

(A department of Mineral Community Hospital)

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Name (please print): _____

Date of Birth: _____ **Phone Number:** _____

I hereby authorize disclosure of my protected health information as follows: (check all that apply)

☐ Provider Notes	☐ Lab Reports	☐ Radiology Reports
☐ Physical Therapy	☐ Sleep Study Reports	☐ ENT Clinic Reports
☐ Procedure/Surgery Reports	☐ Emergency Room Reports	☐ Consultation Reports
☐ **Please Initial** _____ Information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services, and treatment for alcohol and drug abuse.		
☐ Other (please describe):		

Records for the following date(s) of service_____

The above-described PHI is to be released to:

Name/Entity Mineral Community Hospital Clinic

Address 1208 6th Ave East, Superior State Montana

Zip Code 59872 Phone (406) 822-4803 FAX (406) 822-3848

Purpose: ☐ Transfer of Care ☐ Self ☐ Legal ☐ Other

I understand that:

- There is a fee as permitted under MT 50-16-540 for copying medical records.
- I may revoke this authorization at any time by notifying MCH in writing except that revocation will not cancel any action taken by MCH upon the original Authorization for Release of PHI. For instructions on revocation please see MCH's Notice of Privacy Practices.
- Mineral Community Hospital, its employees, officers, and providers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. 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 regulations and guidelines. If I have questions about disclosing my health information, I can contact the Health Information Management department at (406) 822-3706.

EXPIRATION DATE: This authorization is effective for six (6) months from the date signed unless otherwise indicated.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization without negative consequences to treatment, payment or health plan enrollment or benefit eligibility, except under certain circumstances.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

If signed by Legal Representative, Relationship to Patient Witness