FALLON MEDICAL COMPLEX
"Friends Healing Friends"

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(406) 778-3331
FAX (406) 778-5455
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Authorization for Access, Use and Disclosure of Protected Health Information (PHI)

Patient Full Legal Name:			Birth Date:
Address:		City:	
State:	Zip Code:	Day Phone #:	Cell #:

Release From:			
Facility Name			
Address:		City:	State:
Zip Code:	E-mail Address:	Phone #	Fax #

Release To:			
Facility/Person/Company/Organization Name:			
Address:		City:	State:
Zip Code:	E-mail Address	Phone#	Fax #

*IF SENDING RECORDS TO FMC, PLEASE MAIL IF MORE THAN 20 PAGES

Purpose: ❑ Continuation of Care ❑Personal ❑ Insurance/WC ❑ Legal ❑ Other (specify): _____

Information To Be Released: I would like copies of the items checked below:

❑ Emergency Report/Records ❑ Hospital Provider Reports ❑ Clinic Provider Report
❑ Laboratory ❑ EKG ❑ Pathology Report ❑ Rehabilitation
❑ Imaging report (MRI/CT/X-RAY/Ultrasound/Mammogram) ❑ Imaging disc
❑ Billing Itemized ❑ Entire Medical Record
❑ Other (specify): _____

For the treatment dates listed: Covering records for the period from _____ to _____

Disclosure Format:

❑ Paper format- US Mail ❑ Electronic -USB Drive/Disc ❑ Electronic Fax ❑ Review Only
❑ Paper format- Pick up ❑ Other (specify): _____
❑ Email unsecure/unencrypted

****Health Information sent via <u>unencrypted email</u> may place risk of inappropriate access to the information contained within the email. ****

****I accept the risk if I direct Fallon Medical to send my health information via unsecure means. *Init:* _ _____****

Access Format:

❑ Patient Portal Access-This will require a login. Please provide an Email Address _____
*You will be sent a link to get signed up.

The information to be released may include a diagnosis or reference the following condition(s): Please check all that apply:

❑ Behavioral/mental health care ❑ Mental/physical/sexual abuse ❑ Sickle cell anemia ❑ Genetic testing
❑ Acquired immune deficiency syndrome (AIDS) or human immunodefiency virus (HIV) ❑ Sexually transmitted disease
❑ Drug and/or alcohol substance use/abuse disorders. ***Init.*** _____

CONTINUED ON OTHER SIDE >>>>>>>>>>

The following information which includes a diagnosis or reference the following condition(s) may <u>NOT</u> be released: Please check all that apply:

❑ Behavioral/mental health care ❑ Mental/physical/sexual abuse ❑ Sickle cell anemia ❑ Genetic testing
❑ Acquired immune deficiency syndrome (AIDS) or human immunodefiency virus (HIV) ❑ Sexually transmitted disease
❑ Drug and/or alcohol substance use/abuse disorders. ***Init.*** _____

Patient Access/Release Information

- I will submit a copy of a picture ID if requesting information by fax, mail, or email.
- I will provide a picture ID prior to accessing my medical record.
- I may review my medical record without a charge. If I request copies of my medical record, I may receive the first copy without a charge, additional copies may be charged.
- I will refer my questions regarding treatment, prognosis, or other clinic matters to my physician.
- A HIM professional will supervise the review of my medical record.

I Understand That

- Without my express revocation, this authorization will automatically **expire 1 year** from the date signed below, unless I request an expiration date less than 1 year. I may revoke this authorization in writing at any time, except to the extent that action has already been taken to comply with it.
  Information disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and is **no longer protected by the HIPAA Privacy Rule,** unless the disclosed includes records from a federally-assisted programs specifically proving diagnosis, treatment or referral for treatment of drug and alcohol abuse, in which case redisclosure is prohibited under **42 CFR Part 2.**
- The disclosed information above may, in some instances, be re-disclosed by the individual/entity receiving the information In these instances the disclosed information is **no longer protected by the HIPAA Privacy Rule and FMC is not responsible for its disclosure**
- **NOTE:** Protected health information obtained after the date of the signature may not be released under this authorization. An individual cannot authorize release of records that have not yet been created.
- Fallon Medical Complex will not condition treatment on whether the individual sign the authorization.
- The above individual (patient/resident/legal representative) may inspect or receive a copy protected health information to be used or disclosed as provided in **§164.524 of the Privacy Act.**
- All release of information payments will be made directly to Fallon Medical Complex when fees are applicable.

Patient/Authorized Representative* Signature:	**Date:**
Printed Name of Patient/Authorized Representative:	***Relationship to Patient:***
****If you are an authorized representative (other than a parent of a minor child), you will need to provide documentation of your authority to act for the patient (e.g., Health Care Power of Attorney, Executive of deceased patient).**	

For Office Use Only	
Witnessed Signature:	**Date:**
Date Released:	***Released by:***