AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's name ______________________________ ID # _____________ Date of Birth ____________

I give my permission for the University Health Partners Medical Services at Montana State University to release my personal health and medical information as described below to the following:

Name ____

Address ____
City State/zip

Phone # _________________________________ Fax # ____________________________________

Records to be: mailed _______ faxed_______ patient will pick up _______ phone calls only _________

INITIAL the information to be disclosed:

___ clinical notes
___ lab reports
___ annual exam/pap
___ x-ray report
___ x-ray images/CD
___ sexual health/sti's
____ immunization records
___ formal psychiatric evaluation
___ mental health
___ All Records

Dates of treatment: ______________________________

The information for which I am authorizing disclosure will be used for the following purpose:
____ Continuing treatment with other health care providers
____ Other ____

- I understand that this authorization is voluntary, and that I may revoke the authorization at any time by presenting my written revocation to University Health Partners – Medical Services. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that if the recipient is not a health plan or health care provider covered by federal privacy regulations, the released information may no longer be protected by federal privacy regulations.
- This authorization will expire in six months.
- **I understand that this may include information regarding HIV/AIDS, sexually transmitted diseases, mental health status or treatment for alcohol and drug abuse.**
- I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.

By signing below, I understand and acknowledge the following

- That I have read and understand this authorization.
- If I have any questions about disclosure of my protected health information, I may contact the University Health Partners Medical Services at Montana State University.

Signature of patient:__________________________________ Date:_______________

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Accredited by Accreditation Association for Ambulatory Health Care, Inc.

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