MONTANA STATE UNIVERSITY

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's name _____ ID# _____Date of Birth_____

I authorize **(name & address of health care provider releasing your records)**

Name: _____

Address: _____
City **State/zip**

Phone #: _____ Fax #:_____

INITIAL the information to be disclosed:

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

Dates of treatment: _____

To: University Health Partners – Medical Services
MSU – Bozeman
PO Box 173260
Bozeman, MT 59717-3260
Fax number: 406-994-2504
Phone number: 406-994-2311

The information for which I am authorizing disclosure will be used for continuing treatment with other health care providers.

- I understand that this authorization is voluntary, and that I may revoke the authorization at any time by presenting my written revocation to the health care provider listed above. 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 unless stated otherwise.
- **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: _____

University Health Partners
Medical Services
P.O. Box 173260
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Accredited by Accreditation Association for Ambulatory Health Care, Inc.

Mountains & Minds