



Authorization to Release Health Care Information From VPH

Patient Label

Patient Name: _____ Date of Birth: ____/____/____
Phone: _____ Previous Names: _____

I request my protected health information (PHI) from:

Vista Plains Health Ph: 406-632-4351
25 US Highway 191, Harlowton, MT 59036 Provider: _____

Releasing Records to:

Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
Email (if format requested below): _____

Specific Information Being Requested: *Please check all that apply.*

- Hospital Medical Records Clinic Medical Records Immunization Records Laboratory
- Imaging Billing Records Therapy Notes All Medical Records Available
- Specific Date(s): _____ to _____ **If no dates are specified, the last two (2) years will be released.**
- Other: _____

I specifically authorize the release of information in my health record which may include information related to:

- Behavioral or Mental Health Issues Sexual Assault Nurse Examiner Reports Sexually Transmitted Diseases
- Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Alcohol and Drug Treatment

Format Requested: Paper Documents will be mailed if no format is selected.

- No Records sent at this time/Verbal use only. Please keep on file. Electronic Fax Paper Format-Mail
- Pick up in person (if not picked up within 14 days, records will be mailed)
- Electronic E-mail (size limit applies. If too large to e-mail, paper will be mailed. **Health information sent via unencrypted email may place risk of inappropriate access to the information contained within the e-mail. I accept the risk of this if I did direct Vista Plains Health to send my health information via unsecure means.**

Expiration Date: If no expiration date is indicated, this form expires six months after it is signed.

- 3 months 6 months Other: _____

By signing this authorization, I understand that:

- I understand that my drug and/or alcohol treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and my health information is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Part 160 and 164. My information cannot be disclosed without my written authorization unless otherwise provided for by the regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and resented to the WMH's Health Information Management Department. I understand that I cannot revoke authorization for information that has already been released in response to this authorization. Additional information regarding the individual's right to revoke authorization is found in VPH's Notice of Privacy Practices.
- I understand that this authorization is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive treatment, payment for service, enrollment or eligibility for benefits. I understand that I may inspect or copy this authorization as provided in 45 CFR 164.524.
- I understand that any disclosure of information under this authorization carries with it the potential for an unauthorized re-disclosure by the recipient and, after it is disclosed, the information may not be protected by state or federal confidentiality rules.
- If I have questions about disclosure of my health information, I can contact VPH's Health Information Management Department.

Patient/Authorized Representative* Signature: _____

Printed Name of Authorized Representative: _____

Date: _____ Time: _____ Relationship to Patient: _____

*If signed by a patient's authorized representative, supporting legal documentation must accompany this authorization form.