FRANCES MAHON DEACONESS HOSPITAL

# AUTHORIZATION AND/OR REQUEST TO USE OR DISCLOSE HEALTH INFORMATION (ELECTRONIC OR PAPER)

PATIENT NAME: _____ RECORD #: _____

PATIENT PHONE NUMBER: _____ DATE OF BIRTH: _____

**1. Requesting information from (please check those that apply):**

☐ Frances Mahon Deaconess Hospital
621 3rd Street South
Glasgow MT 59230

☐ Glasgow Clinic
221 5th Avenue South
Glasgow MT 59230

☐ Practitioner: _____

**2. Specific information requested (include dates where appropriate):**

**HOSPITAL**

☐ Entire hospital medical record
☐ Specific hospital visit from (date) _____ to (date) _____
☐ Other _____

**CLINIC OR PHARMACY**

☐ Entire clinic medical record
☐ Specific clinic visit from (date) _____to (date) _____
☐ Other _____

**3**. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

**4. Releasing information to:**

☐ Self :
Address: _____
_____
Fax number (if applicable): _____

☐ Name: _____
Address: _____
_____

**5. Information will be used for the following purpose(s):**

☐ My personal records ☐ Sharing with other health care providers ☐ Other (please describe):_____

**6.** I understand that I have the right to revoke this authorization at any time. I understand that if I revoked this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that once the above information is disclosed, it may be re-disclosed by the recipient, and the information may not be protected by federal privacy laws or regulations.

**7. This authorization will expire**: _____
(not to exceed 30 months from signing)

**If I fail to specify an expiration date or event, this authorization will expire 6 months from the date on which it was signed.**

**8.** I understand authorizing the use of disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment.

**9. Signature**

_____ _____
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE DATE/TIME

_____
RELATIONSHIP TO PATIENT (IF LEGAL REPRESENTATIVE)

_____ _____
SIGNATURE OF WITNESS DATE/TIME

***Copy of this form to patient if requested***