Billings OB GYN ASSOCIATES

1611 Zimmerman Trail • Billings, MT 59102 • Phone: (406) 248-3607 • Fax: (406) 248-4881
www.billings-obgyn.com

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth _____

Address: _____ SS#: _____

City:_____ State: _____ Zip: _____

Previous Name:_____ Phone #:_____

I request medical information from:

Physician: _____

Address: _____ Phone: _____

City:_____ State: _____ Zip: _____

Medical information to be disclosed to:

Name: _____

Address: _____ Phone: _____

City:_____ State: _____ Zip: _____

I authorize the following information to be released from my medical record:

☐ Complete Record ☐ Physician Notes ☐ Laboratory Reports

☐ Other (specify) _____

The patient (or patient representative) must read and initial the following statement:

_____I understand that this may include information relating to (please check each box)

☐ Drug or Alcohol Use / Abuse
☐ HIV or AIDS
☐ Sexually Transmitted Disease
☐ Behavioral Health Services / Mental Health

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Authorization is for the following purposes:

☐ Personal Copy ☐ Transfer of Care ☐ Second Opinion

☐ Insurance Company ☐ Medical Leave

☐ Other (specify)_____

The patient (or patient representative) must read and initial the following statements:

_____I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits.

_____I understand there may be a fee associated with this disclosure. Please allow 7-10 business days to process your request.

_____I understand that information disclosed under this authorization may be re-disclosed by the recipient and no longer protected under the federal privacy regulations. The recipient may be prohibited under federal law from re-disclosing substance abuse information, AIDS/HIV status, or mental health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

_____I understand that I may cancel this authorization at any time by notifying the Billings OB-GYN Associates Privacy Officer in writing, but if I do, it won't have any effect on actions taken prior to receipt of the cancellation.

_____Unless otherwise cancelled, I understand this authorization will expire after six (6) months

or on the following date:_____

Signature:_____ Relationship: _____
(Patient / Parent / Guardian / Patient Representative)

Witness:_____ Date:_____

OFFICE USE ONLY
If authorization is signed by an individual authorized by the patient, confirm a copy or obtain a copy of one of the following is in the medical record:

☐ Healthcare Power of Attorney
☐ Legal Guardianship Papers

Record released by:_____ Date:_____ By: Fax Mail Pick Up