Billings OB GYN ASSOCIATES

1611 Zimmerman Trl, Billings, MT 59102 Phone: (406) 248-3607 Fax: (406) 248-8919

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:_____ Date of Birth:_____
Address:_____SS#:_____
City:_____ State: _____Zip:_____
Previous Name:_____ Phone #:_____

I request medical information FROM:

Physician (s):_____
Address:_____Phone #:_____
City:_____ State: _____ Zip:_____

Medical information to be disclosed TO:

Name:_____
Address:_____ Phone #:_____
Fax # (if you have it): _____
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 representative) must read and INITIAL the following statement:

_____I understand that this may include information relating to (please check each line).
_____Drug or Alcohol Use / Abuse
_____HIV or AIDS
_____Sexually Transmitted Disease
_____Behavioral Health Services / Mental Health

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 that 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 authorization will expire after six (6) months or on the following date:_____

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