AUTHORIZATION FOR RELEASE OF INFORMATION

1611 Zimmerman Trail, Billings, MT 59102 Phone: (406) 248-3607 Fax: (406) 248-3608

Patient Name:_______________________________ Date of Birth:__________
Address:_______________________________
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:____________

If records are being disclosed to Billings OB/GYN Associates and are over 60 pages, please mail.

I Authorize the following information to be released from my medical record:
_______Complete record _______Physician Notes _______Laboratory Reports _______Pregnancy Records
_______Other (specify)_______________________________

Additional Authorization to release SENSITIVE information. Please read and INITIAL each item to be released:
_______Alcohol/Drug Treatment/Testing Records
_______HIV or AIDS Related Information
_______Sexually Transmitted Disease Information
_______Behavioral Health Services / Mental Health Testing/Treatment (except psychotherapy notes)
_______Genetic Testing Information

Authorization is for the following purposes:
_______Personal Copy _______Transfer/Continuity of Care _______Second Opinion _______Disability _______Life Insurance

_______Legal purposes _______Worker's Comp _______ 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 it may take approximately 7-10 business days to process my request.
_____ I understand that information disclosed under this authorization may be redisclosed by the recipient and no longer protected under the Federal privacy regulations. The recipient may be prohibited under Federal law from redisclosing 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 will not 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: _______________________________ **Date:**____________________
Circle one: (Patient / Parent / Legal Guardian

Chad Abbey, DO * Kari Bates, DO * Kyla Carlson, DO * Chimene Dahl, MD
Dana C. Edwards, MD * Douglas Neuhoff, MD * Julianna Papez, DO * Rindo Sironi, MD
Aimee Brown, PA-C * Doreen Kenfield, PA-C * Kaitlyn Steele, PA-C * Lindsay R. Cantwell, DNP * Sarah Koppany, PA-C