Billings OB GYN ASSOCIATES

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 #: _____
Fax # (if you have it) _____
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 AND ARE OVER 80 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:_____

Circle one:

Signature:_____(Patient/Parent/LegalGuardian) **Date:**_____

Chad Abbey, DO * Kari Bates, DO * Chimene Dahl, MD * Dana C. Edwards, MD
Julia C. Middleton, MD * Rindo Sironi, MD *Aimee Brown, PA-C * Doreen Kenfield, PA-C
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