General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Patient Name: ____

Address: ____

____

Phone: ______________________ Email: ______________________

SSN: ______________________Date of Birth:_____/_____/_____

I authorize the custodian of records of: or other person/entity (specifically describe) to disclose/release the following information* (check all applicable):

- All records
- Laboratory/pathology records
- X-ray/radiology records
- Billing records
- Abstract/Summary
- Pharmacy/prescription records
- Other (descr ibe specifically)

These records are for services provided.

Please send the records listed above to:

The Montana Caregivers Network Doctors and Medical Assistants (or "**MCN**")
Fax Numbers:

(804) 518-4938		(509) 210-0201
(804) 414-9863	**(406) 203-4833**	(509) 210-0297
(616) 855-6774	**(406) 203-4834**	(509) 210-0103

(In case one is busy, try one of the others)

The information may be used/disclosed for each of the following purposes:

- At my request (only the patient can check this box)
- For my health care
- For payment/insurance
- For employment purposes

☑Other: To see a travelling specialist.

This authorization shall expire no later than: 01/01/2018, and may not be valid for greater than seven (7) years from the date of signature for Montana medical records. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further 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; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

____
Signature of patient (or patient's personal representative)

____
Date

____
Printed name of patient or representative

____
Representative's authority to sign for patient, *(i.e. guardian, power of attorney, executor)*

You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to the Privacy Liaison, 3800 Reservoir Road, N.W. Washington, DC 20007.

A copy of this signed authorization must be given to the individua l.

If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.