AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
Kalispell OB-GYN Associates, P.C.

Date: _____

Patient Name: _____Date of Birth: _____

Last 4 of SSN: XXX-XX-_____

Information to be released TO:

Kalispell OB-GYN Associates, P.C.
165 Commons Loop, Suite E
Kalispell, MT 59901

PH: 406-752-5252
FX: 406-752-5261

Information to be used for the purpose of:
☐Requested by Patient ☐ Other _____

This information may be given to and used by the following individual or organization.
I hereby request and authorize you to release information from:

Name_____
Address_____
_____
_____

Disclosure Method
☐ Pickup ☐ Mail
☐Fax #_____
☐Other _____

I authorize the use or disclosure of the above named individual's health information as described below.
Information to be released:

☐ All Records of Treatment from _____ to _____

☐ Entire (Complete Record)	☐ Medication Record	☐ Allergy List	☐ Genetics
☐ History & Physical Report	☐ Physician's Orders	☐ X-ray Reports	☐ Lab Results
☐ Consultation Report	☐ Progress Notes	☐ Drug/Alcohol Information	☐ HIV Results
☐ Operative Report	☐ Psychiatry Information	☐ Immunization Record	

☐ Other _____

- I understand that the information in my health record may include information relating to sexually transmitted disease, behavioral or mental health services, and treatment for alcohol and drug abuse.
- I understand there will be a charge for copying records.
- I understand that if the person or entity that receives the information is not a healthcare or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in the federal privacy regulations.
- Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify and expiration date, event or condition, this authorization will expire in six months.
- I understand that I may revoke this authorization in writing at any time by contacting the Privacy Officer at Clinic Name; telephone number.
- I understand that this revocation does not apply to information that has already been released in response to this authorization.
- Failure to sign this authorization
  - ☐ Will have no adverse impact on delivery of care or reimbursement of patient charges
  - ☐ Will have the following adverse impact:

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to Patient Signature of Witness

For Office Use Only: Copied By:	Check ID Type: _____ Date Copied:	Amount Received:

- I revoke (cancel) this Authorization to Disclose Health Information previously signed on _____(date).

Cancellation Signature: _____ Date: _____