773-1067_06-21-24 (Web)

ROI Pt

Bozeman Health

Patient Label
Name: _____
DOB: _____
M#: _____

AUTHORIZATION FOR USES & DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

INSTRUCTIONS: Please submit this completed form to:

Bozeman Health Deaconess Hospital, ATTN: Medical Record Department, 915 Highland Boulevard, Bozeman, MT 59715
Telephone: (406) 414-1055, Fax: (406) 414-1069. Email: medrecords@bozemanhealth.org
*Form must be completed in its entirety. Incomplete form could delay response.

PATIENT INFORMATION:

Patient Name: (Last, First, Other/Alias)	DOB:	Phone#:
Address:	City:	State/Zip:

PURPOSE OF DISCLOSURE:

☐ Transfer of Care ☐ Referral ☐ Personal Records ☐ Legal ☐ Insurance
☐ Other (specify): _____

INFORMATION TO BE RELEASED:

☐ Specific Date(s) From: _____ to _____
☐ All past, present and future encounters/visits

ENTIRE RECORD

☐ Entire Medical Record ☐ Pertinent Only (Provider Notes & Test Results)

SPECIFIC NOTES/RESULTS

☐ ER Record
☐ Operative Reports
☐ Discharge Summary
☐ History/Physical
☐ Immunizations
☐ Rehabilitation Summary
☐ Home Oxygen
☐ Billing Statement/Claim
☐ Consultations
☐ Lab/Pathology Reports
☐ Physician Clinic Record (Provider Names)
_____
_____
☐ Other: _____
_____

RADIOLOGY

Bozeman Health Radiology
☐ Entire Record ☐ Report Only ☐ Images Only

Advanced Medical Imaging (AMI)
☐ Entire Record ☐ Report Only ☐ Images Only

DELIVERY OPTIONS

☐ Mail
☐ Pick Up
☐ Secure (encrypted) Email (List): _____
☐ MyChart (Epic Only)
☐ Machine Readable Format (EHI)

EFFECTIVE: You may choose to provide an event (related to you or the purpose of the use/disclosure) upon which your authorization will expire. Otherwise, this authorization will expire twelve months after the date of signature. Event: _____

INFORMATION TO BE RELEASED FROM:

☐ Bozeman Deaconess Regional Medical Center
☐ Big Sky Medical Center and Clinics
☐ Bozeman Health Urgent Care ☐ Convenience Care

_____
_____
Phone: _____
Fax: _____

INFORMATION TO BE RELEASED TO:

☐ Self (patient) or ☐ Third Party **Supporting documentation may be required

_____
_____
Phone: _____

Fax (Healthcare Facilities Only): _____

****If releasing to a Third Party,**
I acknowledge that the released information may contain alcohol, drug abuse, HIV, and mental health information. It is my intent that informtaion released is prohibited for any other purpose than that which is stated above.

I understand that:

1. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
2. I may revoke this authorization at any time by giving written notice to the office listed above, but if I do, it will not have any effect on actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requestor or receiver is not subject to federal health information privacy laws (not a health plan or health care provider), the released information may no longer be protected by federal privacy regulations and may be redisclosed.
4. I may be charged a $15.00 administrative fee, plus $.50/page, depending on the specifics of this request.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient Representative:	Date:
Printed Name of Patient/Patient Representative:	*Relationship or scope of your legal authority to act on the patient's behalf: