Family Medicine Center
of the Bitterroot, P.C.

330 N. 10th Street, Ste. A • Hamilton, MT 59840 • Phone: 406-363-DOCS(3627) • Fax: 406-363-3638 • www.familymedcenter.org

RELEASE RECORDS FROM FAMILY MEDICINE CENTER

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

(1) I hereby authorize to disclose the following information from the health records of:

Patient Name: _____ Date of Birth: _____
(first name, middle initial, last name)

Address: _____
(street, state and zip code)

Telephone: _____ Social Security # _____

(2) This information to be disclosed to: Name: _____
Address: _____
_____

(3) This information to be disclosed will be used for: _____.

(4) Covering the period(s) of healthcare: _____.

(5) Information to be disclosed: All Medical Records including: Progress Notes, Lab Reports, X-ray Reports, History ad Physical examinations, Discharge Summaries, Consultation Reports, Emergency Room Records, Operative Notes, Pathology Reports, Home Health Records and Hospice Records.

(6) I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

(7) I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire six (6) months from the date of signing.

(8) The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

(9) I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Administrator of Family Medicine Center of the Bitterroot, P.C.

(10) I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____
Signature of Patient or Legal Representative Date

If signed by Legal Representative, indicate relationship to the patient _____