Health Solutions PLLC

1001 SW Higgins Ave STE 103
Missoula, Montana 59803

Phone: 406.543.5444
Fax: 406.543.5447

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH CARE INFORMATION

I hereby authorize _____

to release information from the medical records of:

_____

Patient's Name printed Date of Birth SSN

TO**: HEALTH SOLUTIONS** at 1001 SW Higgins Ave; STE 103, Missoula, MT 59803: Fax: 406-543-5447

The information for which I'm authorizing disclosure will be used for the following purpose:
[ ] My personal records
[ ] Sharing with other health care providers as needed
[ ] Other (please describe)_____

The type of information to be used or disclosed is as follow (check all that apply):
[ ] Discharge Summary
[ ] Radiology reports
[ ] Immunization records
[ ] History and Physical
[ ] ECG
[ ] Other: _____
[ ] Lab results (dates and types) _____
_____
_____
[ ] Consultation report from _____
[ ] Entire record
_____
_____

I understand that the records released may contain the following information which is protected by state and/or federal law and authorize you to release this information (you must initial all those that apply):
_____ Mental Health Treatment
_____ Substance Abuse
_____ AIDS/HIV related information

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. Unless I specify differently, this authorization will expire _____. If I fail to specify an expiration date or event, **this authorization will expire in six months** from the date on which it is signed. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal or state privacy laws or regulations. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I acknowledge that I may be charged a reasonable, cost-based fee for making copies. I acknowledge that third-party payers and other parties requesting health information on behalf of myself with authorization will be charged as state law allows.

_____

Signature of patient or legal representative Date

_____

Relationship to patient