COMMUNITY HEALTH PARTNERS

Patient Label
Name:_____
DOB:_____
M:_____

Community Health Partners

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (ROI)

INSTRUCTIONS: Submit the completed form to Community Health Partners.
ATTN: Medical Records Department, Phone: (406)922-0840 Fax: (406)388-3461
This form MUST be completed in its entirety, incomplete forms cannot be processed.

PATIENT INFORMATION		
Patient Name: (PRINT) (Last, First, Other/Alias)	**DOB:**	**Phone:**
Address:	**City:**	**State/zip:**

Purpose of Discloser:
☐Legal ☐Insurance ☐Personal ☐Continuation of Care ☐Transfer of Care ☐School
☐Other (specify)_____

I authorize the following protected health information (PHI) from Community Health Partners be disclosed to:

Recipient Name (Person/Company/Organization:	**Phone:**	**Fax:**
Street Address or P.O. Box	**City:**	**State/zip:**

Information to be Released: place a checkmark in the boxes below indicating what information should be released. Include the designated time frame. If any of the information is incomplete, we may be unable to fulfill this request.

Specific Date(s)_____

- ☐ Clinic Notes (progress notes) _____
- ☐ Lab Reports _____
- ☐ Pathology _____
- ☐ Radiology _____
- ☐ Immunizations _____
- ☐ Medication List _____
- ☐ Other (specify) _____

If you would like any of the following sensitive information disclosed, check the applicable box(es) below: Include the designated time frame. If any of the information is incomplete, we may be unable to fulfill this request.

Specific Date(s)_____

- ☐ Alcohol/Drug Abuse Treatment/Referral _____
- ☐ Sexually Transmitted Diseases _____
- ☐ HIV/AIDS-related Treatment _____
- ☐ Mental Health _____
- ☐ Psychotherapy Note ONLY: by checking this box, I am waiving any psychotherapist-patient privilege _____
- ☐ Other (specify) _____

Delivery Options	☐ My Chart	☐ Mail	☐ Pick up (paper copy)	☐ Fax

By signing this authorization form, I understand that:

- The information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.
- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Medical Records Department at the following address: CHP-Belgrade, 19 E Main St., Belgrade, MT 59714. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this authorization will expire 90 days from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

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

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

Completed by Community Health Partners: Record Pickup- ID Verified by: _____ Date Verified by: _____