COMMUNITY HEALTH PARTNERS
REAL PEOPLE. REMARKABLE HEALTHCARE.

Patient Label

Community Health Partners

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (ROI)

INSTRUCTIONS: Submit the completed form to Community Health Partners.
ATTN: Health Information Management, 19 E. Main St. Belgrade, MT 59714
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 Disclosure:

☐ Personal (self)	☐ Legal
☐ Insurance	☐ Continuation of Care
☐ Transfer of Care	☐ School
☐ Other(Specify)_____	

Delivery Options:

☐ Mail	☐ Pick-Up (Paper Copy)
☐ Fax: (Healthcare Facilities Only)	☐ My Chart (EPIC Records Only)
☐ Secure (Encrypted) Email:	

Type of Disclosure

_____ • I authorize Community Health Partners to **RELEASE** (send) copies of my medical records to **(only records created by CHP will be released)**:

_____ • I authorize Community Health Partners to **DISCUSS** my health with:

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 designated time frame. If a time frame is not specified, only the last two years of records will be released. If any of the information is incomplete, we may be unable to fulfill this request.

Specific Date(s)_____

☐ Clinic Notes (Progress Notes)	☐ Immunizations
☐ Lab Reports	☐ Medication List
☐ Pathology	☐ Radiology (Report Only)
☐ Other (Specify)	

If you would like any of the following sensitive Information disclosed, check the applicable box(es) and sign below: Include 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	☐ Mental Health
☐ Sexually Transmitted Diseases	☐ HIV/AIDS-related Treatment
☐ Psychotherapy Notes Only: by checking this box I am waiving any psychotherapist-patient privilege.	
***Signature Required:**	

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: Records Pick-up: ID Verified By:_____ Date Verified By:_____