Missoula City-County Health Department
HEALTH SERVICES
301 W Alder Street| Missoula, MT 59802-4123
PHONE | 406.258.4750

AUTHORIZATION FOR THE DISCLOSURE OF HEALTH INFORMATION

Federal law says that we cannot share your health information without your permission except in certain situations. If you sign this form, you are giving us permission to share the health information you indicate below. This does not prevent the information from being re-shared by the recipients.

Please complete the following information for the request of records:

Client Name: _____ Date of Request: _____

Other names used: _____ Date of Birth: _____

The purpose of this records request is (please select one):

☐ Client Request ☐ Other: _____

I am requesting the following protected health information to be released from MCCHD (please check):

☐ Immunization Records (this includes immunization records recorded in imMTrax) ☐ Travel Clinic Medical Records

☐ Tuberculosis Screening/Treatment ☐ Laboratory Results ☐ Home Visiting Records ☐ DPP Records

☐ RD/nutrition Records Other: _____

Specific Date(s) _____ to _____ Specific Information only: _____

Please release the selected protected health information:

☐ I will pick up at 301 W. Alder **OR**

Please send my records via: ☐ Mail ☐ Fax ☐ Email Other: _____

Individual/Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Encrypted Email: _____ Check this box to verify your email is legible and correct

Unless otherwise revoked, this authorization will expire one year after it is signed. By signing this authorization, I acknowledge that:

- My record may contain information regarding the screening for HIV (human immunodeficiency virus), other bloodborne pathogens (Hepatitis B, Hepatitis C), or sexually transmitted diseases. I give my specific authorization for these records to be released.
- Only records maintained by Missoula City-County Health Department will be released.
- With this request on file, immunization records from the State Registry imMTrax, also can be released.
- I have the right to revoke this authorization at any time. Revocation must be done in writing. I understand that I cannot revoke an authorization for information that has already been released in response to this authorization.
- This authorization is voluntary. I can refuse to sign this authorization. I need not sign this authorization to receive treatment, payment for services, enrollment, or eligibility for benefits.
- I may inspect or copy this authorization as provided in 45 CFR 164.524. I understand that any disclosure of information under this authorization carries with it the potential for an unauthorized re-disclosure by the recipient and, after it is disclosed, the information may not be protected by state or federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Missoula City-County Health Department Health Services Division Director.

Client/Authorized Representative* Signature _____ Date: ____/____/____

By signing this form, I agree that the information I provided is accurate and truthful and I agree with the acknowledgement and consent above.

***Parent, Legal Guardian, or Legal Representative. Supporting legal documentation must accompany this form when services are requested by the client's Legal Guardian or Legal Representative.**

Please Print Your Name: _____ Relationship to Client: _____

Office Use Only (check all when complete): ☐ Photo ID ☐ Signed paperwork

☐ Records released ☐ Paperwork scanned to client chart Staff initials

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AUTHORIZATION FOR THE DISCLOSURE OF HEALTH INFORMATION

Federal law says that certain health providers cannot share your health information without your permission except in certain situations. If you sign this form, you are giving the health provider identified below permission to share the health information you indicate below. This does not prevent the information from being re-shared by the recipients.

Please complete the following information for the request of records:

Client Name: _____ Date of Request: _____

Other names used: _____ Date of Birth: _____

The purpose of this records request is (please select one):

☐ Client Request ☐ Other: _____

I am requesting the following protected health information to be released TO MCCHD (please check):

☐ Clinic Medical Records ☐ Hospital Records ☐ Dental Records ☐ Psychiatric/Counselor ☐ Therapist
☐ Pathology Records ☐ Immunization Records ☐ Laboratory records ☐ Imaging Records (X-Rays, CT, MRI etc)
☐ Tuberculosis Screening/Treatment Specific Date(s): _____ to _____
☐ Specialist: _____ Specific Information only: _____
Other: _____

Please confirm contact information for where MCCHD is requesting your protected health information from:

Individual/Organization: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
Email: _____

Unless otherwise revoked, this authorization will expire <u>one year</u> after it is signed. By signing this authorization, I acknowledge that:

- My record may contain information regarding the screening for HIV (human immunodeficiency virus), other bloodborne pathogens (Hepatitis B, Hepatitis C), or sexually transmitted diseases. I give my specific authorization for these records to be released.
- Only records maintained by the provider identified above will be released.
- I have the right to revoke this authorization at any time. Revocation must be done in writing. I understand that I cannot revoke an authorization for information that has already been released in response to this authorization.
- This authorization is voluntary. I can refuse to sign this authorization. I need not sign this authorization to receive treatment, payment for services, enrollment or eligibility for benefits.
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☐ Records released ☐ Paperwork scanned to client chart Staff initials