

HEALTH SERVICES

301 W Alder Street| Missoula, MT 59802-4123 PHONE | 406.258.4750

Staff initials



Records released

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 fo					u oot:	
Client Name: Other names used:						
			_ Date of Diffi			
The purpose of this red	-		•			
Client Request	Other:					
I am requesting the fol	lowing protect	ed health inf	ormation to	o be released	from MCCHE) (please check):
Immunization Reco	rds (this includes in	nmunization rec	ords recorded	in imMTrax)	Travel Clinic	Medical Records
Tuberculosis Screen	Laborator	Laboratory Results Home Visiting Records DPP F				
RD/nutrition Record	ls	Other:				
Specific Date(s)	toSpo	ecific Informatio	n only:			
Please release the sele	cted protected	health info	rmation:			
I will pick up at 30	01 W. Alder	OR				
lease send my records via:	Mail	Fax	Email	Other:		
Individual/Organi						
Pho <u>ne:</u>			Fax:			
Encrypted Email:				Ch	eck this box to ver	rify your email is legible and correct
 B, Hepatitis C), or sexuall Only records maintained With this request on file, I have the right to revoke authorization for informa This authorization is voluservices, enrollment, or or authorization carries with be protected by state or City-County Health Depa Client/Authorized Represe By signing this form, I agree that the 	nformation regardily transmitted disease by Missoula City-Communization receive this authorization ation that has alreadintary. I can refuse eligibility for benefits authorization as play it the potential for federal confidentiar trent Health Service of the information I profile regresentative. Su	ng the screening ases. I give my stounty Health Doords from the Stat any time. Redy been release to sign this authts. Drovided in 45 Corran unauthorizality rules. If I havices Division Divie	g for HIV (hum pecific author epartment wil rate Registry in vocation musted in response norization. I new FR 164.524. It is deed re-disclosu we questions a rector.	nan immunodeficization for these ization for these ization for these is be released. InMTrax, also can be done in writing to this authorizated not sign this action and that are by the recipients about disclosure of the second in the second is agree with the action is agree.	iency virus), othe records to be released. ng. I understand tion. authorization to reany disclosure of int and, after it is coff my health information. Data	r bloodborne pathogens (Hepatitiseased. That I cannot revoke an eceive treatment, payment for information under this disclosed, the information may normation, I can contact Missoula
Please Print Your Name:	Relationship to Client:					
Office Hee Only /	chock all when	a complete):	Dh	oto ID	Signed pan	erwork

Paperwork scanned to client chart



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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 reshared by the recipients.

Client Name:		Date of Request:Date of Birth:				
Other names used:						
The purpose of this re	cords request is (please sele	ct one):				
Client Request	Other:					
am requesting the fol	lowing protected health info	rmation to be release	d 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/T	reatment	Specific Date(s):	to			
Specialist:		Specific Information only:				
Other:						
	State					
\ddress:						
=						
	Fax:					
:mail:						
B, Hepatitis C), or sexual Only records maintained I have the right to revoke authorization for inform This authorization is volu services, enrollment or e I may inspect or copy the authorization carries wit be protected by state or	information regarding the screening of ly transmitted diseases. I give my spead by the provider identified above will be this authorization at any time. Revolution that has already been released untary. I can refuse to sign this authorization as provided in 45 CFR is authorization as provided in 45 CFR in it the potential for an unauthorized federal confidentiality rules. If I have	for HIV (human immunodeficific authorization for these leased. I be released. I be released. I be a cation must be done in writin response to this authoriz rization. I need not sign this least a 164.524. I understand that it re-disclosure by the recipied questions about disclosure	ciency virus), other bloodborne pathogens (Hepa e records to be released. ting. I understand that I cannot revoke an ation. authorization to receive treatment, payment for any disclosure of information under this ent and, after it is disclosed, the information may			
My record may contain in B, Hepatitis C), or sexual Only records maintained I have the right to revoke authorization for inform This authorization is voluservices, enrollment or a I may inspect or copy this authorization carries with be protected by state or City-County Health Depart	information regarding the screening of ly transmitted diseases. I give my spead by the provider identified above will be this authorization at any time. Revolution that has already been released untary. I can refuse to sign this authorization as provided in 45 CFR is authorization as provided in 45 CFR in it the potential for an unauthorized federal confidentiality rules. If I have artment Health Services Division Directions.	for HIV (human immunodeficific authorization for these leased. I be released. I be released. I be response to this authorizin response to this authorizing rization. I need not sign this lease is a 164.524. I understand that it re-disclosure by the recipies questions about disclosure ctor.	ciency virus), other bloodborne pathogens (Hepa e records to be released. ting. I understand that I cannot revoke an ation. authorization to receive treatment, payment for any disclosure of information under this ent and, after it is disclosed, the information may e of my health information, I can contact Missoula			
My record may contain in B, Hepatitis C), or sexual Only records maintained I have the right to revoke authorization for inform This authorization is volus services, enrollment or element or copy this authorization carries with be protected by state or City-County Health Department (Authorized Represerving Sysigning this form, Lagree that	Information regarding the screening of ly transmitted diseases. I give my spead by the provider identified above will be this authorization at any time. Revolution that has already been released untary. I can refuse to sign this authorization as provided in 45 CFR is authorization as provided in 45 CFR in it the potential for an unauthorized federal confidentiality rules. If I have artment Health Services Division Direct antative* Signature	for HIV (human immunodeficific authorization for these leased. In the second in response to this authorization. I need not sign this least a 164.524. I understand that it re-disclosure by the recipiest questions about disclosure ctor.	ciency virus), other bloodborne pathogens (Hepa e records to be released. ting. I understand that I cannot revoke an ation. authorization to receive treatment, payment for any disclosure of information under this ent and, after it is disclosed, the information may of my health information, I can contact Missoula Date:			

Photo ID