Authorization for Use or Disclosure of Protected Health Information

Patient: _____ Date of Birth: _____

I authorize the custodian of records at:

Facility, Provider, Clinic _____

Address _____

Phone/Fax _____

to release the following information:

❒ All Records* (including administrative forms and referrals) ❒ Visit notes

❒ Pharmacy/prescription records ❒ Radiology reports (CT, MRI) ❒ Lab results

Other records:_____.

For the range of dates from: _____ to _____.

I understand and agree that the information below will only be disclosed if I place my initials in the applicable space next to that information.

_____ HIV/AIDS treatment ____Mental Health treatment ____Drug and Alcohol Abuse

Send the records to

Montana Headache Clinic, PLLC
2831 Fort Missoula Road, Ste 204
Missoula, MT 59804
Secure Fax: 406.213.9980

I understand that I have the right to revoke this authorization at any time, but to do so I must send a written statement that I am revoking the authorization along with a copy of this authorization to Montana Neurology. 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 with the right to contest a claim under my policy.

Unless I specify differently, this authorization will expire (insert date) _____. If I fail to specify an expiration date, this authorization will expire six months from the date on which it was signed.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient, and federal or state privacy laws and regulations may not protect the information. I understand authorizing the use or disclosure of the information identified above is voluntary. I do not need to 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 or other parties requesting health information on behalf of myself with my authorization will be charged as state laws allow.

_____ _____ _____

Signature of Patient or Representative Date Relation to Patient