**Hansen Family Practice, LLC**

2300 12th Ave. S. Suite 128 Phone: (406) 866-0280

Great Falls. MT 59405 Fax: (406) 866-0270

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH CARE INFORMATION

I herby authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To release information for the medical records of

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name Printed Date of Birth SSN

To: **HANSEN FAMILY PRACTICE, LLC** at 2300 12th Ave. S. Suite 128, Great Falls, MT 59405

Fax 406 866-0270

The information for which I’m authorizing disclosure will be used for the following purposes:

[ ] My personal records

[ ] Sharing with other health care providers as needed

[ ] Other (please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The type of information to be used or disclosed is as follow (check all that apply)

[ ] Discharge Summary [ ] Lab results (dates and types)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Radiology \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Immunization Records \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] History and Physical [ ] Consultation Report from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] ECG [ ] Entire Record

[ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the records released may contain the following information which is protected by state and/or federal law and authorize you to release this information (you must initial all those that apply):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mental Health Treatment

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Substance Abuse

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AIDS/HIV related information

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless I specify differently, this authorization will expire \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

If I fail to specify an expiration date or event, **this authorization will expire in six months** from the date signed. I understand that once the above information is disclosed, it may be disclosed by the recipient and the information may not be protected by federal or state privacy laws or regulations. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

­­­­­­­Signature of patient or legal representative Date

Relationship to patient