Livingston HealthCare

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

LIV0002

Failure to provide all information may invalidate this authorization

Print Patient Name: _____ **Date of Birth**: _____

Purpose of Request: ☐ Transition of Care ☐ Authorize Another's Access ☐ Other: _____

I authorize information to be released:

From:	**To:**
_____	_____
Address:	Address:
_____	_____
Phone, Fax, or Email (circle one):	Phone, Fax, or Email (circle one):
_____	_____

Livingston Healthcare: 320 Alpenglow Lane, Livingston, MT 59047 ~ (406) 823-6412 ph (406) 823-6630 fax

Types of information to be released:

☐ Lab Reports
☐ Image Reports
☐ Images via USB or Email? (circle 1)
If by email, do you have PC or MAC?
☐ Office Visits
☐ Emergency Dept
☐ Hospital Stay
☐ Immunizations
☐ Outpatient Rehab
☐ Operative Reports
☐ Home Health & Hospice
☐ Pathology
☐ Urgent Care
☐ Billing Records

☐ Other:_____ Dates of Service:_____

Re-Disclosure and Right to Revoke:
I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I may revoke this authorization at any time by presenting a written revocation to the Medical Records Department. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. I understand the revocation will not apply to information that has already been released in response to this authorization.
UNLESS REVOKED, THIS AUTHORIZATION WILL EXPIRE IN 180 DAYS OR ON THE FOLLOWING DATE:_____

Sensitive Information: Additional laws relating to the use and disclosure of the information listed below may apply. I understand and agree with the disclosure of the information I have checked below:

☐ HIV/AIDS
☐ Mental health
☐ Genetic testing
☐ Drug/alcohol diagnosis
☐ Sexual assault information
☐ Sexually Transmitted Disease

Signature of Patient or Personal Representative Requesting Disclosure:
I understand that I am not required to sign this authorization. Refusal to sign the authorization will not adversely affect my ability to receive healthcare services or reimbursement for services. The only circumstance when refusal to sign means I will not receive healthcare services is if the healthcare services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. If I have questions about disclosure of my health information, I can contact Livingston HealthCare Medical Records.

_____
Signature of Patient (parent if a minor child) or Legal Representative Date:

_____
Description of Legal Representative's Authority Phone:

Print Name of Representative: _____

STAFF USE ONLY
Date: _____ ID Verified: ___ Staff Initials:_____ Delivery Method: ☐ Fax ☐ E-mail ☐ Mail ☐ Retrieved # of pages_____