



**AUTHORIZATION FOR DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

*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:**

<b>From:</b> _____ <b>Address:</b> _____ <b>Phone, Fax, or Email:</b> _____	<b>To:</b> _____ <b>Address:</b> _____ <b>Phone, Fax, or Email:</b> _____
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*Livingston Healthcare: 320 Alpenglow Lane, Livingston, MT 59047 ~ (406) 823-6412 ph (406) 823-6630 fax*

**Types of information to be released:**

- Imaging Reports     Images on CD     Office Visits     Outpatient Rehab     Pathology
- Lab Reports     Emergency Dept     Operative Reports     Urgent Care
- Immunizations     Hospital Stay     Home Health & Hospice     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     Genetic testing     Sexual assault information
- Mental health     Drug/alcohol diagnosis     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**

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Description of Legal Representative's Authority**

**Phone:** (\_\_\_\_\_) \_\_\_\_\_

**Date:** \_\_\_\_\_

**STAFF USE ONLY**

**Date:** \_\_\_\_\_ **ID Verified:** \_\_\_\_\_ **Staff Initials:** \_\_\_\_\_ **Delivery Method:**  Fax  E-mail  Mail  Retrieved **# of pages** \_\_\_\_\_