



Rocky Mountain
 Ear, Nose & Throat Center, P.C.

AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION
(Authorization to release patient's records from other health care provider)

TO: _____
 (health care provider)

 (address)

 (city, state, zip)

RE: _____
 (patient's name)

You are hereby authorized and directed to release health care information related to the above named patient's present or past medical condition to:

Dr. _____
 Rocky Mountain Ear, Nose, & Throat Center, P.C.
 700 West Kent
 Missoula, MT 59801

Information to be disclosed:

- All healthcare information in your possession, whether generated by you or transferred from other sources, unless specifically limited below
- Only healthcare information generated by you unless specifically limited below.

You are **not** authorized to release the following:

- AIDS or HIV-related information
- Alcohol or drug treatment information
- Mental-health information
- Other Restrictions (specify): _____

Dates of Service To Be Released: From _____ To _____

For the purpose of: ___ legal ___ insurance ___ evaluation and treatment Other: _____

Revocation

This authorization is subject to revocation at any time by giving written notice to the Health Care Provider. The revocation is effective from the time it is received by the Health Care Provider and does not apply to actions taken by the Health Care Provider prior to that.

Expiration

If not revoked, this authorization terminates thirty months from the date of its execution, or on _____.

Acknowledgments

I understand that the information that is disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and therefore may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand I do not have to sign this authorization as a condition of receiving treatment from the Health Care Provider unless my treatment is research related or purpose of treatment is to generate information for a third party.

 Patient Name (Please Print)

 Date of Birth

SS# _____ - _____ - _____

 Signature of Patient or Patient's Representative

 Relationship to Patient

 Date