Rocky Mountain ENT

MAIN OFFICE

MISSOULA 700 W. Kent | Missoula, MT 59801 | **P:** 406.541.**EARS** (3277) or 800.255-8698 **F:** 406.541.3950

SATELLITE OFFICES

HAMILTON 120 S. 5th St., Suite 104 | Hamilton, MT 59840 | **P:** 406.363.7049 **F:** 406.363.2223

Authorization to Release HealthCare Information

I _____ hereby authorize Rocky Mountain Ear, Nose, & Throat Center, P.C. to release my medical records to:

_____

Name

_____ _____ _____

Address City/State Zip Code

I intend for Rocky Mountain Ear, Nose, & Throat Center, P.C. to release the following information (Check One)

❍ All healthcare information in its possession, whether generated by Rocky Mountain Ear, Nose, & Throat Center, P.C. or transferred from other sources.

❍ Only healthcare information generated by Rocky Mountain Ear, Nose, & Throat Center, P.C.

Unless specified otherwise, we do not routinely release supplemental information such as audiograms and X-Rays. If you want us to release any of these items, please check the appropriate boxes. **PLEASE NOTE THAT RELEASE OF THESE ITEMS MAY INCUR A CHARGE FOR DUPLICATION.** Fees for duplication will be provided upon request, and are in conformance with provisions of MCA §50-16-526:

❍ Audiograms ❍ X-rays

❍ Other Please Specify: _____

If there is specific information you **DO NOT** want us to release, please specify by checking the box:

❍ Records generated by other providers ❍ AIDS or HIV-related information

❍ Alcohol or drug treatment information ❍ Mental health information

❍ Other (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 Privacy Officer as indicated in the Notice of Privacy Practices. The revocation is effective from the time it is received by Rocky Mountain Ear, Nose, & Throat Center, P.C. and does not apply to actions taken by Rocky Mountain Ear, Nose, & Throat Center, P.C. 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 Rocky Mountain Ear, Nose, & Throat Center, P.C. 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 Social Security Number

_____ _____ _____

Signature of Patient or Patient's Representative Relationship to Patient Date/Time