Livingston HealthCare
Billings Clinic Affiliate

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Failure to provide all information may invalidate this authorization.

Patient Name:______________________________

Date of Birth:______________ Patient Phone:______________________

Purpose of Request:

❑ Personal Records ❑ Transition of Care/Follow-up ❑ Insurance ❑ Other:______________

I authorize information to be released *FROM*:

❑ Livingston HealthCare
320 Alpenglow Lane
Livingston, MT 59047

❑ Facility Name:______________________
Address:______________________
____
Phone/FAX:______________________

Individual/Agency/Facility I would like information to be *SENT* to:

❑ Name:______________________
Address:______________________
____
Phone/FAX:______________________

❑ Livingston HealthCare HIM Department
320 Alpenglow Lane
Livingston, MT 59047
(406) 823-6412 FAX: (406) 823-6630

Types of information to be released:

❑ All Records (past 2 years)
❑ Imaging Reports: □ CD
❑ Clinic Records
❑ Emergency Records
❑ History & Physicals
❑ Lab Reports
❑ Operative Reports
❑ Other:______________________
❑ Consultations
❑ Pathology
❑ Discharge
❑ Urgent Care
❑ Immunizations
❑ Home Care & Hospice

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:

If the information to be disclosed contains any of the types of information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed by checking the applicable space next to the type of information.

❑ HIV/AIDS information
❑ Mental health information
❑ Genetic testing information
❑ Drug/alcohol diagnosis
❑ Sexual Assault information
❑ Sexually Transmitted Disease

Signature of Patient or Personal Representative Requesting Disclosure:

I do not need 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 or Legal Representative ***Date***

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Description of Legal Representative's Authority

STAFF ONLY Documents Released:______________________ To Be: ❑ Mailed ❑ Faxed ❑ Retrieved
Date:______________ ID Verified:______________________ Staff Initials:______________