PHILLIPS COUNTY HOSPITAL & FAMILY HEALTH CLINIC

P.O. Box 640 Malta, Montana 59538 (Ph) 406- 654-1100 (Fax) 406-654-5070

Patient Name: _____ Date of Birth:_____

1. The following organization is authorized to make the disclosure:

   _____

2. What information is to be disclosed: Please initial

	History and Physical		Medication List
	Laboratory Results		Chart Notes
	Radiology Results		Entire Record
	Nurses Notes		Financial Information

Other: _____

3. This information may be disclosed to the following individuals or organization:

   _____

4. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires. If I fail to specify an expiration date or event this authorization will expire in six months according to Montana State Law.
5. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management of Phillips County Hospital and Family Health Clinic. I understand that the revocation will not apply to information that has already been released. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
6. I understand that authorizing the disclosure of this health information is voluntary; I can refuse to sign this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact Phillips County Hospital and Family Health Clinic (406)654-1100, and ask for the Privacy Officer.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Relationship to Patient Signature of Witness

UPDATED 03/14/22