

AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

SHODAIR HOSPITAL
2755 COLONIAL DRIVE
P.O. BOX 5539 HELENA, MT 59604
(406) 444-7500 OR 1-800-447-6614

NAME OF PATIENT: _____

BIRTHDATE: _____ MEDICAL RECORD NUMBER:

**I hereby authorize Shodair Hospital to: Request information from:
Disclose information to:**

Name/Agency: _____

Address: _____

City, State, Zip: _____

Phone Number: _____ Fax Number: _____

This information will be used to facilitate evaluation, treatment, and aftercare services for the patient and the family.

INFORMATION REQUESTED/TO BE DISCLOSED: (CHECK ALL THAT APPLY)

- | | | |
|-------------------------------|-----------------|---------------------------|
| H&P/Medical | Educational | Psychiatric/Psychological |
| Office Notes | Consultations | Chemical Abuse/Dependence |
| Lab/Special Reports | Treatment Plans | Discharge Summary |
| Immunization Record | Social History | Legal |
| Other (Please specify): _____ | | |

This authorization will remain valid for a period of 30 (thirty) months from date of signature unless revoked before that time as described below.

I understand that this authorization for release of information may be revoked at any time in writing unless disclosure is required to effectuate payments for health care that has been provided or other substantial action has been taken in reliance on the authorization. Leaving treatment at Shodair against medical advice does not, in and of itself, constitute a revocation of this authorization for release of information. Shodair Hospital may not condition treatment or payment on whether an individual signs this authorization.

The potential exists for information disclosed pursuant to this authorization to be re-disclosed by the recipient and no longer be protected by federal law. The undersigned person(s) agree to indemnify and hold harmless Shodair Hospital and its employees from all claims or liability that may arise as a result of Shodair's compliance with this authorization.

Date _____ Signature of Parent/Legal Guardian (Circle Applicable Status)

Witness _____ Signature of Patient

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 C.F.R.) Part 2 prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal Regulations state that any person who violates any provision of this law shall be fined not more than \$500 in the case of the first offense and not more than \$5,000 in the case of each subsequent offense.

For Shodair Use Only: Date Records Requested _____ Date Records Received _____
ROI.1/W.FILE/RELEASES FD: 6/22/00 REV: 4/03 REV: 5/06
