Partnership Health Center (PHC)
Medical Records Department
323 W Alder St, Missoula, MT 59802
PHONE: (406) 258-4789 option 5 / FAX: (406) 258-4732

Patient Name: _____ Date of Birth: _____

Other Name(s)Used / Maiden Name:_____ Phone Number: _____

REQUEST COPY OF MY PROTECTED HEALTH INFORMATION FROM:

Physician/Facility/Entity: _____ Phone: _____
Address: _____ Fax: _____
City: _____ State: _____ Zip: _____

Purpose for requesting information: (Please check one) ☐ Patient Request ☐ Co-Management with a Specialty Provider
☐ Other ☐ Continuation of Care

I am requesting the following of my protected health information to be released to PHC: (Must **initial** those that apply)

_____ Clinic Medical Records _____ Imaging Records (X-Rays, MRIs, CT Scans, etc.)
_____ Laboratory Records _____ Pathology Records
_____ Psychiatric Records _____ Immunization Records
_____ Specific Date(s): _____ to _____
_____ Specific Information only: _____

RELEASE MY PROTECTED HEALTH INFORMATION TO: (Two Options Below - Please check **ONLY** one)

1. _____ I am requesting a copy of my health records for myself. (Initial the records you are requesting below.)

2. _____ I am requesting **Release** of my protected health information to the following Physician/Person/Facility/Entity:

Physician/Person/Facility/Entity: _____ Phone: _____
Address: _____ Fax: _____
City: _____ State: _____ Zip: _____

I am requesting PHC **release** my protected health information initialed below: (Must **initial** all that apply)

_____ Clinic Medical Records _____ Immunization Records _____ My appointments scheduled
_____ Laboratory Records _____ Pathology Records _____ Billing Information
_____ Psychiatric Records _____ Specific Date(s): _____ to _____
_____ Specific Information only (list): _____

By signing this authorization, I understand that:

a. My records may contain information regarding the diagnosis or treatment of AIDS (acquired immunodeficiency syndrome) or infection with HIV (human immunodeficiency virus), substance abuse (drugs and/or alcohol), psychiatric/psychological or mental health care, or sexually transmitted diseases. I give my specific authorization for these records to be released.
b. Only records generated by Partnership Health Center will be released.
c. I have the right to revoke this authorization at any time. Revocation must be done in writing. I understand that I cannot revoke an authorization for information that has already been released in response to this authorization.
d. This authorization is voluntary. I can refuse to sign this authorization. I need not sign this authorization to receive treatment, payment for services, enrollment or eligibility for benefits.
e. I may inspect or copy this authorization provided in 45 CRF 164.524. I understand that any disclosure of information under this authorization carries with it the potential for an unauthorized re-disclosure by the recipient and, after it is disclosed, the information may not be protected by state or federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Partnership Health Center's Medical Records Department.

Patient/Authorized Representative *Signature: _____Date: _____

* If signed by a patient's authorized representative, supporting legal documentation must accompany this authorization form.

Witness signature (only required for Mental Health Records): _____ **EXPIRATION DATE**: _____

Revised: 3/6/15, 3/19/15, 11/17/15,2/3/16 , 08/25/16, 2/26/18

Unless otherwise revoked, this authorization will expire six months after it is signed