AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

(Authorization to release patient's records from other health care provider)

TO: _____ **RE**: _____
(*health care provider)* *(patient's name)*

_____
(*address)*

_____
(*city, state, zip*)

You are hereby authorized and directed to release health care information related to the above named patient's present or past medical condition to:

Dr. _____
Rocky Mountain Eye Center, P.C.
700 West Kent
Missoula, MT 59801

Information to be disclosed:

☐ All healthcare information in your possession, whether generated by you or transferred from other sources, unless specifically limited below

☐ Only healthcare information generated by you unless specifically limited below.

You are **not** authorized to release the following:

☐ AIDS or HIV-related information

☐ Alcohol or drug treatment information

☐ Mental-health information

☐ Other Restrictions (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 Health Care Provider. The revocation is effective from the time it is received by the Health Care Provider and does not apply to actions taken by the Health Care Provider 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 the Health Care Provider unless my treatment is research related or purpose of treatment is to generate information for a third party.

_____ _____ SS#_____ - _____ - _____
Patient Name (Please Print) Date of Birth

_____ _____ _____
Signature of Patient or Patient's Representative Relationship to Patient Date