



Patient Sticker

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTHCARE INFORMATION – DPHHS

Please check all applicable boxes in all sections.

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

- Discharge Summary, Lab/Medical/Consultations, Psychiatric/Psychological, Treatment Plans, Educational, Chemical Abuse/Dependence, Social History, Legal History, Office Notes, Other (Please specify):

Purpose: This information will be used for: Continuity of Care, Social Services Guardianship, Patient Advocacy, Other:

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES/DEPARTMENT OF FAMILY SERVICES

Shodair Hospital may request above protected healthcare information from this agency YES NO
Shodair Hospital may disclose above protected healthcare information to this agency YES NO

Name, Address, City, State, Zip, Phone, Fax

This authorization will remain valid for a period of 12 (twelve) 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 by sending such revocation in writing to the HIM Director at 2755 Colonial Drive, Helena, MT 59601.

Date, Signature of Parent/Legal Guardian (Circle Applicable Status), Witness, Print Name of Patient, DOB

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.