Shodair
CHILDREN'S HOSPITAL

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTHCARE INFORMATION

Please check all applicable boxes in all sections.

☒ I give my permission to Shodair Hospital to request information from the individual/agency listed below.

☒ I give my permission to Shodair Hospital to disclose information to the individual/agency listed below.

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

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): *VERBAL COORDINATION OF CARE*

Name/Relationship_____

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. Shodair will comply with the revocation 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 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. 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.

ROI – DPHHS FD: 6/15 REV: 1/16