Broadwater Health Cent

Caring since 1905

Authorization for Inspection, Use, Disclosure and Release of Protected Health Information

Print Name: _____ Date of Birth _____

Address: _____

City: _____ State: _____ Zip Code: _____

Last 4 digits Social Security #: _____ Telephone: (_____)_____

1. Information to be Released-Period of Health Care

Month/Year_____ Month/Year _____

Discharge Summary	**Physicians Orders**	**X-ray**
Completed Health Record	**Emergency Dept. Visit**	**Laboratory Test Results**
History & Physical Exam	**Entire Visit**	**Progress Notes**
Other		

2. The Information to be Released is to be used for the Purpose Of:

Attorney	**Personal**	**At the request of the Individual**
Workers' Comp	**Disability**	**Others**

3. Person Authorized to Disclose Information **Person Authorized to Receive Information**

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse, I agree to its release.

If NO initial her and specify _____

4. Time Limit & Right to Revoke Authorization

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire 90 day from the date of signing. To revoke my authorization, I must submit in writing to **Broadwater Health Center, Attn HIM, 110 N Oak Street, Townsend, Mt 59644.**

5. Re-disclosure/Treatment

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby release from any legal responsibility of liability for disclosure of the above information. I understand that BHC will not condition treatment on my signing this authorization. BHC will not deny treatment if I do not wish to sign this authorization.

Patient Signature: _____ Date: _____

Authority to Sign if not patient: _____

6. Identity of requestor Verified via: Photo ID Matching Signature Other (Specify):_____

Original to Health Information Management Copy to Patient Form last updated 03-28-16