# PUREVIEW Health Center

**AUTHORIZATION TO DISCLOSE PATIENT HEALTH INFORMATION**

**1930 9th Avenue - Helena, MT 59601**

**Phone: (406) 457-0000 Option # 5- Fax: (406) 500-2128**

**Email: medicalrecords@pureviewhealthcenter.org**

**1. Patient Name, AKAs:** _____ **DOB:** _____/_____/_____

**Patient Address:** _____ **State:** _____ **Zip Code:** _____ **Phone:** _____

**2. Self**_____ **Must show government issued ID to pick up records in person.**

**I authorize PureView Health Center to (check only one)** _____ **Receive/Discuss** _____ **Release/Discuss my record** _____**Both**

**Name:** _____

**Address:** _____ **City:** _____ **State:** _____ **Zip Code:** _____

**Phone:** _____ **Fax:** _____

**3. Covering a time from Dates:** _____/_____/_____ **to** _____/_____/_____ **(**If time frame is not specified, most recent 3 visit notes will be provided.)

**4. Purpose of Release (check any that apply)**

- ○ Personal Use/Review
- ○ Transfer of Care (Transferring care from PVHC. Please close my chart.)
- ○ Continuity of Care
- ○ Legal
- ○ Insurance (Payments/Claims)
- ○ Other: (please specify) _____

**5. Information to be Released/Received (check any that apply)**

- ○ Clinic Notes
- ○ Laboratory Tests
- ○ Pathology Reports
- ○ Imaging Reports
- ○ Consultation Reports
- ○ Medication Records
- ○ Immunization/Allergy Records
- ○ Billing
- ○ Dental Images
- ○ Other: (please specify) _____

**6. The below records will NOT be released unless checked:**

- ○ Alcohol and Drug Info/Treatment
- ○ Psychiatric/Behavioral Health
- ○ AIDS/HIV/STD Testing and Result

**7. This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here:** _____/_____/_____

This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation. PureView Health Center Notice of Privacy Practice describes how to cancel (revoke) this authorization.

PureView Health Center will not restrict my treatment if I choose not to sign this authorization.

A photocopy/fax of this authorization will be treated in the same way as an original.

PureView Health Center cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release PureView Health Center from any and all liability resulting from a redisclosure by the recipient.

**Confidentiality of Alcohol and Drug Abuse Patient Records:** Any records disclosed by PureView pursuant to your consent granted by this ROI will contain a notice to the receiving party about further disclosure of the records in one of the following formats: 1) This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFRT part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see§ 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at§§ 2.12(c)5 and 2.65; OR 2) 42 CFR part 2 prohibits unauthorized disclosure of these records.

**I authorize PureView Health Center to contact me by phone, text or email. I understand that while PureView will use reasonable safeguards to protect text and email communications, no electronic communication is guaranteed to be secure.**

Your signature indicates that you have read and understand this form and authorize release of your information as described above.

**8.** Patient/Authorized Representative Signature: _____ Date: _____

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

Witness signature: _____ Date: _____

****For a speedy return of records, please complete this form in its entirety.****

(Revised 7/2023)