



**FALLON
MEDICAL
COMPLEX**

"Friends Healing Friends"

Release of Information

Fallon Medical Complex **Community Clinic**

PO Box 820
202 South 4th Street West
Baker, MT 59313-0820
(406) 778-3331
FAX (406) 778-5455
www.fallonmedical.org

Patient Full Legal Name:		Birth Date:
Address:	City:	
State:	Zip Code:	

Medical Record Number at Fallon Medical Complex: (Completed by Medical Records Department - Not applicable for Clinic Use)
The undersigned hereby authorizes and requests <input type="checkbox"/> Fallon Medical Complex or <input type="checkbox"/> Community Clinic to provide copies of his/her medical record to the individual/facility below:
Name of Individual or Institution:
Address of Entity to be released to: _____
Reason:

Please send the following copies of my medical record to the before-named entity as soon as possible:

Confined to records regarding admission and/or treatment for the following medical condition or injury:

Covering records for the period from _____ to _____

No limitations placed on dates, history of illness, or diagnostic and/or therapeutic information, **INCLUDING** any treatment for
 alcohol drug abuse mental health records HIV testing or treatment of AIDS or AIDS related conditions
Signer must initial for authentication of this response Init. _____

No limitations placed on dates, history of illness, or diagnostic and/or therapeutic information, **EXCLUDING** any treatment for
 alcohol drug abuse mental health records HIV testing or treatment of AIDS or AIDS related conditions
Signer must initial for authentication of this response Init. _____

Signature: <i>The above-named individual has the right to refuse to sign this authorization.</i>	Date:
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If signed by personal representative, state relationship & authority to do so:

Witness:	Date:
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Date Information was Released:	Releaser's Initials:
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- *This authorization expires one (1) year from the date of signature.*
- *This authorization may be revoked at any time by submitting request in writing to the above address.*
- *The disclosed information above may, in some instances, be re-disclosed by the individual/entity receiving the information In these instances the disclosed information is no longer protected by the HIPAA Privacy Rule and FMC is not responsible for its disclosure*
- *NOTE: Protected health information obtained after the date of the signature may not be released under this authorization. An individual cannot authorize release of records that have not yet been created.*
- *FMC/Community Clinic will not condition treatment, payment, continued enrollment in a health plan, or eligibility for benefits based on the individual providing appropriate authorization.*
- *The above individual(patient/resident/legal representative) may inspect or copy protected health information to be used or disclosed as provided in §164.524 of the Privacy Act.*
- *A third party will compensate FMC directly or indirectly when disclosure will result in such compensation.*