FALLON MEDICAL COMPLEX &
COMMUNITY CLINIC

Health Information Management Department

202 South 4th Street West ♦ PO Box 820 ♦ Baker, Montana 59313-0820
Direct Line: 406-778-5118 OR 406-778-3331 Extension 261 ♦ FAX (406) 778-5145

Release of Information

❑ **Fallon Medical Complex** ❑ **Community Clinic** ❑ **Both**

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

Medical Record Number at Fallon Medical Complex:
(Completed by Medical Records Department - Not applicable for Clinic Use)

The undersigned hereby authorizes and requests ❑ **Fallon Medical Complex** or
❑ **Community Clinic** to provide copies of his/her medical record to:

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 or ❑ drug abuse or ❑ mental health records.**
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 or ❑ drug abuse or ❑ mental health records.**
Signer must initial for authentication of this response Init. _____

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

Date Information was Released:	**Releaser's Initials:**

- ***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.***