BULLHOOK
Community Health Center

521 4th Street Havre, Montana 59501 • Phone: 406-395-4305 • Fax: 406-395-5643 • ww.bullhook.com

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

NAME OF PATIENT:_____DOB:_____MRN:_____

DATE OF SERVICE:_____

I HEREBY AUTHORIZE:_____

TO DISCLOSE THE BELOW INFORMATION TO BULLHOOK COMMUNITY HEALTH CENTER

INFORMATION TO BE DISCLOSED:

****I understand that this may include information relating to alcohol and/drug abuse, behavioral health and/or other highly confidential information obtained during the course of my diagnosis and treatment****

CHECK THE FOLLOWING:

__Complete medical record(s)—or specifically those parts checked below:

__Discharge Summary	**__Pathology Reports**	**__Emergency Room Notes**
__History and Physical Exam	**__Progress Notes**	**__Eye Exam Results**
__Consultation Reports	**__Laboratory Tests**	**__ PAP/Well Woman Exam**
__Operative Notes	**__X-ray/Imaging Reports**	**__Pain Contract**

__Accounting of Disclosures

__Billing Information

__Photographs, videotapes, digital or other images

__Psychotherapy Notes

__Other (Please Specify):_____

PURPOSE OF DISCLOSURE;_____

EXPIRATION DATE OR EVENT:_____

(Expires in 6 months if not specified)

****I understand that this authorization may be revoked in writing at any time to the HIM Department, except for the disclosure already made in response to this authorization.****

****I understand that treatment, payment, enrollment or eligibility benefits may not be affected by me signing this authorization unless allowed by the Federal Privacy Laws.****

****I understand that this information is re-disclosed by the recipient, it may no longer be protected by the Federal Privacy Law.****

_____ _____

Signature of Patient OR personal representative and (description of authority) **Date**

_____ _____

Witness