Bullhook Community Health Center (BCHC)
521 4th Street, Havre, MT 59501
Phone: (406) 395-4305 ● Fax: (406) 395-5643

BULLHOOK Community Health Center

RELEASE OF RECORDS & RECORDS REQUEST FORM

I, ____, born ____/_____/_____ SSN______/____/______
hereby authorize ____ to release to:

Name of Person or Organization: ________________________________ Phone: _____________________
Organization Contact Name: ___________________________________ Fax: ________________________
Address: ____
City: ____ State: _________________ Zip Code: __________

Please send the following information: (mark all that apply):

☐Medical Record ☐Dental Record ☐Labs ☐Immunization Record ☐Other ____________________

*I understand that the records sent may contain information which are protected by state and/or federal law and I do not need to agree to send them. If I still want you to send those records, I will check them below:
☐*Mental Health Treatment ☐*Substance Use Disorder Treatment ☐*AIDS/HIV related information
I am consenting with my signature here: ____ Date: __________

Drug and/or alcohol treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and health information is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Part 160 and 164. Information cannot be disclosed without written authorization unless otherwise provided for by the regulations.

By signing this form, I understand that:

a) I have the right to change my mind at any time. If I cancel this release it must be done in writing. I understand some records may have already been sent before I cancel this release.
b) I choose to sign this form. I can also refuse to sign this form. 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.
c) I may see a copy of this form as per law 45 CFR 164.524. I understand that once my notes are sent to someone else, the information may not be protected by State or Federal Privacy Laws.

Patient/Authorized Representative Signature: ____________________________________*Date: _____________
*If signed by a patient's authorized representative, supporting legal documentation must accompany this authorization form.

Witness signature: ____

EXPIRATION DATE: ___________________ ***Unless otherwise revoked, this authorization will expire twelve months after it is signed.***

Confidentiality of Alcohol and Drug Abuse Patient Records: Section 2.32, Prohibition on Re-disclosure of Confidential Information
This notice may contain a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom in pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.