NORTH VALLEY HOSPITAL

**Health Information Management**
**1600 Hospital Way • Whitefish, MT 59937**
**phone (406) 863-3547 • fax (406) 863-3645**

# AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

**Patient Name:** _____ **Date of Birth:** _____
**Address:** _____ **Phone Number:** _____
_____

**I hereby authorize North Valley Hospital to disclose my Protected Health Information (PHI) to the following:**

Name: _____
Address: _____
_____
Phone number: _____

**Disclosure to occur in the following manner:**
❒ Pick up at NVH ❒ Meditech Viewing at NVH
❒ Mail ❒ Fax # _____

**I am requesting copies of the following information created between _____/_____/_____ and _____/_____/_____:**
*(check appropriate boxes)*

| | | |
|---|---|---|
| ❒ Discharge Summary | ❒ Physician Orders | ❒ Psychotherapy Notes |
| ❒ History & Physical | ❒ Physician Progress Notes | ❒ Rehab |
| ❒ Consultation | ❒ Radiology Reports | ❒ Billing Information |
| ❒ ER Report | ❒ Laboratory | ❒ Other _____ |
| ❒ Operative Report | ❒ Echocardiogram Report | |

**Purpose of requested information:**
❒ Patient followup care ❒ Attorney
❒ Insurance ❒ Other _____

- I understand that North Valley Hospital cannot condition treatment or payment based on the patient signing this authorization.
- I understand that I may inspect or obtain a copy of my PHI to be disclosed.
- I understand that I may refuse to sign this authorization.
- I understand that I may revoke this authorization at any time by notifying North Valley Hospital in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- I understand that once the information described herein is disclosed, it may be redisclosed by recipient and no longer subject to the privacy protections.
- I understand by signing this authorization, above information may include alcohol, drug abuse, mental, and/or other highly confidential information health records obtained in the course of my diagnosis and treatment.

_____ _____
***Patient Signature or Authorized Party*** ***Date***

_____ _____
***Relationship to Patient*** ***Expiration Date***
*(if left blank, authorization expires six (6) months from date on which it was signed)*

_____ _____
***Witness*** ***Date***

*** Copy or Fax is valid as the original ***

*2 copies – 1 for patient* *3/21/07*