TAMARACK
MANAGEMENT, INC.

Health Information Management
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Instructions for Completing Authorization for Release of Information

***** IMPORTANT: ALL Sections must be completed for the form to be valid and processed *****

Below are step-by-step instructions on how to complete the attached form. If you have any questions, please contact our Health Information Management department at either (406) 329-7263 or via email at TamarackHIM@tmimontana.com.

1. **Provide patient information.**

    a. Patient Last Name
    b. Patient First Name
    c. Date of Birth
    d. Social Security (Last 4 numbers)
    e. Patient Address (including city, state and zip code)
    f. Patient Daytime Phone Number

2. **Complete the information in the orange box – this tells us where to send immunization records that are currently located at Western Montana Clinic.**

    a. Only one recipient/outside entity per form.
    b. When indicating the delivery method, please provide complete information (i.e. email, fax number, address).
    c. Incomplete information in this box will cause a delay in fulfilling the request.
    d. Specify the purpose of the request for records to be sent to an outside entity.
    e. Some types of information have additional restrictions (see box outlined under 'Information to be Released'); please **initial** next to each restricted record type you would like to be included in your request.

3. **Sign and date the form. If the patient is under the age of 18 years, a legal guardian must sign and indicate the relationship to the patient.**

    a. Clearly print the name of the person signing the form.
    b. If you choose, indicate a date after which the request/form is no longer in effect. This date can be no more than 30 months after the date of signing. If no date is indicated, the request/form will automatically expire after 12 months.
    c. If signing electronically, include a copy of your photo ID (driver's license).

Authorization for Release of Information
Request of WMC Immunization Records be sent to Outside Entities

***** IMPORTANT: In order for authorization to be valid, ALL areas must be completed *****

Patient Last Name (please print)	First Name	MI	Date of Birth	XXX-XX- Last 4 Social Security Number

Patient Address (PO Box/Street)	City	State	Zip	Daytime Phone Number

Outside Entity Information (must be complete and readable)

Name: _____
(Healthcare Provider / Facility / Individual to receive records)

Delivery Method

☐ **Email**: _____ ☐ Secure ☐ Unsecure

☐ **Fax** (**15 page max.**): _____ (*include mailing address if faxing*)

☐ **Mail**
Address: _____

City/State/Zip: _____

Information to be Released (Check all that apply – the minimum necessary for your purposes)

[X] Immunizations

FOR THE PURPOSE OF _____

I understand and agree that the information below will be disclosed if I place my **initials** in the applicable space next to the type of information.

_____**Drug/Alcohol Abuse** _____**Aids/HIV Related Information** _____**Genetic** _____**Behavioral or Mental Health Issues**

I understand that this authorization may be revoked by me at any time, provided that I do in writing and submit it to the Medical Records Department, up to the extent that the disclosure has not already been made. I also understand that my protected health information may be re-disclosed by the recipient and no longer protected under federal law. Authorization will expire in 12 months unless otherwise specified below.

_____ _____ _____
Patient Signature (if over 18) **Date** **Expiration Date (not to exceed 30 months)**

OR

_____ _____ _____
Legal Representative/Guardian **Relationship to Patient** **Date**

Print Signer's Name: _____

Return to Health Information Management

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