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 blue box** – this tells us where to send 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.

3. **Check the appropriate box(s) under ‘Information to be Released’.**
   a. When completing this section, please be as specific as possible. For most instances, your full medical record is not necessary.
   b. Specify the purpose of the request for records to be sent to an outside entity.
   c. 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.

4. **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   b. If you choose, indicate a date after which the request/form is no longer in effect.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 Records be sent to Another Party

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

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

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

Where we will send the records (must be complete and readable)

Name: ________________________________________________
(This can be you, a facility, or a specific provider)

Delivery Method

☐ MyChart

☐ Email: ___________________________________________   ☐ Secure   ☐ Unsecure

☐ Fax (15 page max.): _______________________________ (MUST include mailing address if faxing)

☐ Mail

Address: _____________________________________________
City/State/Zip: ________________________________________

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

☐ Western Montana Clinic Provider or Department __________________________________________________________
☐ Past (circle one) 2 3 5 years
☐ Only dates of service from ______________ to ______________
☐ Information from medical record for the completion of a disability form
☐ Other _____________________________________________________________________________________________

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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