AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Releasing Facility:
Sweet Medical Center, Inc.
419 Pennsylvania St. P.O. Box 309
Chinook, MT 59523
406-357-2294 Fax: 406-357-3252

Patient Name: _____Date of Birth: _____ SSN: _____

I hereby authorize the disclosure of protected health information about me to:

Name: _____ Information may be disclosed by:
Address: _____ ____ Mail
_____ ____ Fax
_____

I request the release of the following specific information for these specific dates of service.

Records of Treatment for dates from _____ to _____.

___ Entire Record	___ History & Physical	___Operative Reports
___ X-rays	___ Discharge Summaries	___ Physician Orders
___ Lab Reports	___ Progress/Office Notes	___ Medication Records
___ Immunization Record	___ Consultation Report	___ Mental Health Information
___ Allergy List	___ Drug/Alcohol Information	

I understand that:

- Once this information is disclosed, it may be subject to re-disclosure by the recipient and federal privacy laws may no longer protect the information.
- Authorizing the disclosure of health information is voluntary, and I can refuse to sign this authorization with no negative impact on my receiving health care or on the charges for that care.
- I can revoke this authorization at any time by giving a written request to the Privacy Officer at Sweet Medical Center, Inc. This revocation will not apply to information that has already been released in response to this authorization.
- The information in my health record may include information relating to sexually transmitted disease, behavioral or mental health services, or treatment for alcohol/drug abuse.
- There may be a charge for copying the records.
- Unless otherwise requested, this authorization will expire on: _____ or six months from the date of signature.

Signature: _____ _____
Circle One: Patient Parent Spouse Guardian Personal Representative Date