# PHC PARTNERSHIP HEALTH CENTER

Partnership Health Center (PHC)
Medical Records Department
323 W Alder St, Missoula, MT 59802
PHONE: (406) 258-4789 option 5 / FAX: (406) 258-4732

Patient Name: ______________________________________________________ Date of Birth: _____________________

Other Name(s)Used / Maiden Name:_____________________________________ Phone Number: ____________________

**REQUEST** COPY OF MY PROTECTED HEALTH INFORMATION FROM:

Physician/Facility/Entity: _______________________________________________________ Phone: ____________________
Address: _________________________________________________________________ Fax: ______________________
City: ____________________________________________ State: ____________________ Zip: ______________________

Purpose for requesting information: (Please check one) _______Patient Request _______Co-Management with a Specialty Provider
______ Other _______ Continuation of Care

I am requesting the following of my protected health information to be released to PHC: (Must **initial** those that apply)

_________ Clinic Medical Records _________ Imaging Records (X-Rays, MRIs, CT Scans, etc.)
_________ Laboratory Records _________ Pathology Records
_________ Psychiatric Records _________ Immunization Records
_________ Specific Date(s): _________________ to __________________
_________ Specific Information only: ______________________________________________________________________________

**RELEASE** MY PROTECTED HEALTH INFORMATION TO: (Two Options Below - Please check **ONLY** one)

1. _______ I am requesting a copy of my health records for myself. (Initial the records you are requesting below.)

2. _______ I am requesting **Release** of my protected health information to the following Physician/Person/Facility/Entity:

Physician/Person/Facility/Entity: _________________________________________________ Phone: ____________________
Address: ___________________________________________________________________ Fax: ______________________
City: ____________________________________________ State: ____________________ Zip: ______________________

I am requesting PHC **release** my protected health information initialed below: (Must **initial** all that apply)

_________ Clinic Medical Records _________ Immunization Records _________ My appointments scheduled
_________ Laboratory Records _________ Pathology Records _________ Billing Information
_________ Psychiatric Records _________ Specific Date(s): __________________ to __________________
_________ Specific Information only (list): ______________________________________________________________________

**By signing this authorization, I understand that:**

a. My records may contain information regarding the diagnosis or treatment of AIDS (acquired immunodeficiency syndrome) or infection with HIV (human immunodeficiency virus), substance abuse (drugs and/or alcohol), psychiatric/psychological or mental health care, or sexually transmitted diseases. I give my specific authorization for these records to be released.
b. Only records generated by Partnership Health Center will be released.
c. I have the right to revoke this authorization at any time. Revocation must be done in writing. I understand that I cannot revoke an authorization for information that has already been released in response to this authorization.
d. This authorization is voluntary. I can refuse to sign this authorization. I need not sign this authorization to receive treatment, payment for services, enrollment or eligibility for benefits.
e. I may inspect or copy this authorization provided in 45 CRF 164.524. I understand that any disclosure of information under this authorization carries with it the potential for an unauthorized re-disclosure by the recipient and, after it is disclosed, the information may not be protected by state or federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Partnership Health Center's Medical Records Department.

Patient/Authorized Representative *Signature: ______________________________________________Date: ________________

* If signed by a patient's authorized representative, supporting legal documentation must accompany this authorization form.

Witness signature (only required for Mental Health Records): ____________________________ **EXPIRATION DATE**: _____________

**Unless otherwise revoked, this authorization will expire six months after it is signed**