MISSOULA COUNTY PUBLIC SCHOOLS
Forward Thinking, High Achieving

AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

TO: _____ ("Health Care Provider")

RE: _____ ("Patient")

You are hereby authorized and directed to release health care information related to the above-named patient's present or past medical, mental, psychological, and physical condition to the person(s) indicated below.

Information to be disclosed:

____ ALL information and records in your possession related to the Patient's health care, including information not generated by you (except psychotherapy notes as defined by HIPAA).

____ ALL information which is specified: _____

_____

Date Range of Information to be Released: From:_____ To:_____

Persons to whom Information should be disclosed: Name(s)_____

Address_____

Fax #:_____ Email:_____

Purpose of Disclosure: ___Patient Request ___Other ___Parent Request

Method of Disclosure: ___ Pickup ____ Mail ____ Email ____ Fax _____ Other

Disclosure Subject to Revocation/ Expiration: This authorization is subject to revocation at any time by giving written notice to the Health Care Provider. The revocation is effective from the time it is received by Health Care Provider and does not apply to actions taken by the Health Care Provider prior to that.

Expiration: If not otherwise revoked, this authorization terminates twenty-four (24) months from the date of its execution, or on _____

Acknowledgments:

- I understand that the information that is disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and therefore may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this release.
- I understand that I have a right to receive a copy of this Release and may request a copy of the records to be disclosed. I understand that I may be charged for copies of these records in accordance with federal and state law.

DATE signed: _____

_____
(Signature of Patient or Patient's Representative)

(REQUIRED) Patient's Date of Birth: _____

(OPTIONAL) Patient's SS#: _____

_____
(Print Name)

_____
(If Representative, Relationship to Patient)

Revised February 2022