AUTHORIZATION FOR RELEASE OF INFORMATION

ALLERGY AND ASTHMA CENTER OF MONTANA, P.C.
401 – 15th Avenue South, Suite 104
Great Falls, MT 59405-4334
Office: (406)771-9050 Fax: (406)761-1090

Patient Name _____ Date of Birth _____

I hereby authorize (FROM) ___Dr. Elaine Barbieri_____ to release my personal health and medical information as described below to _____

Information to be disclosed:

Complete Health Records	Consultation Reports	Films
ALL Laboratory tests information	Progress Notes	Other_____
Radiology Reports	Discharge Summary _____	

From (date) _____ To (date)_____

I understand that this will include information relating to (check if applicable):

_____Acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV)

_____Behavioral health services/psychiatric care

What is the purpose or use of the disclosure? _____

The patient or patient's representative MUST read and initial the following statements:

I understand that this authorization is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

Initial_____

I understand that I may inspect or receive a copy of the information described on this form if I ask for it and that I will receive a copy of this form after I sign it.

Initial_____

Unless otherwise canceled, I understand that this authorization will expire after 12 months or on the following date, event or condition: _____.

Initial_____

I understand that I may cancel this authorization at any time by notifying the providing health care provider in writing, but if I do, it will not have any effect on actions taken prior to receipt of the cancellation.

Initial_____

I understand that if the person or entity that receives the above information is not a health care provider or a health plan provider covered by federal privacy regulations the released information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. The recipient may otherwise be prohibited under federal law from re-disclosing substance abuse information, AIDS/HIV status or mental health information unless another authorization is obtained by me or unless such use or disclosure is specifically required or permitted by law.

Initial_____

_____Date:_____

(Signature/name of patient and/or patient representative)

If signed by other than patient, indicate relationship: _____

Signature of Physician: _____ Witness:_____ Date: _____