



Central Montana Family Planning

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Central Montana Family Planning
CONFIDENTIAL

Date of Request: _____

AUTHORIZATION FORM TO [] REQUEST/[] RELEASE HEALTH INFORMATION

PATIENT NAME: _____
LAST FIRST MI MAIDEN/OTHER NAME

DATE OF BIRTH: _____ SSN _____ - _____ - _____ MEDICAL RECORD #: _____
MO DAY YR

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: _____ EVENING PHONE: _____

I HEREBY AUTHORIZE CENTRAL MONTANA FAMILY PLANNING TO [] REQUEST/[] RELEASE MY HEALTH INFORMATION [] FROM/[] TO:

NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

HEALTH INFORMATION TO BE REQUESTED/RELEASED:

- I specifically authorize release of the following information:
[] Entire Medical Record OR (check the appropriate box)
LATEST RESULTS:
[] History and physical exam, including Breast * Pelvic Exams
[] Progress notes
[] Substance abuse (including alcohol/drug abuse)
[] Lab reports: GC ___ Chlamydia ___ Pap ___ Other ___
[] Mental health (including psychotherapy notes)
[] Ultrasound reports
[] HIV related information (AIDS related testing)
[] Other: _____
DATES: _____
This Authorization is made for the following purpose:
[] At my request, OR specify: _____

CONDITIONS OF AUTHORIZATION

- 1. This Authorization will expire 1 year after the date of my signature or as otherwise stated here (insert date): _____
2. I may revoke this Authorization at any time by notifying Central Montana Family Planning in writing and it will be effective on the date notified except in the extent that Central Montana Family Planning has already acted upon such Authorization.
3. Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.
4. By authorizing this release of information, my healthcare and payment for my healthcare will not be affected if I do not sign this Authorization form. I have been offered a copy of this agreed Authorization form.
5. I have been informed that Central Montana Family Planning [] will / [] will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.



SIGNATURE OF PATIENT _____ DATE _____ OR _____ PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON _____ DATE _____