FERGUS COUNTY HEALTH DEPARTMENT
Central Montana Family Planning
Montana Cancer Screening Program
Promoting and improving the health of our communities.

Authorization Form to Request/Release Health Information

Date of Request: _____

Patient Name: _____ _____ _____ _____
(Last) (First) (MI) (Maiden/Other Name)

Date of Birth: _____ SSN: _____-_____-_____ Medical Record #: _____
(MM/DD/YYYY)

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: _____

I specifically authorize release of the following information (circled items only, please):

- Entire medical record
- Most recent reports, including –
  - History and physical exam (including breast, pelvic and progress notes)
  - Substance abuse (including alcohol and drug abuse)
  - Lab results – including STI testing/HIV testing and Pap smear or other: _____
  - Mental health – including psychotherapy notes
  - Ultrasound or radiology results
  - Contraceptive history and prescribing information

Conditions of Authorizations:

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.*

_____ _____ OR _____ _____
(Patient Signature) (Date) (Parent/Legal Guardian/Authorized Person) (Date)

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