



Central Montana Family Planning  
Montana Cancer Screening Program

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Date of Request: \_\_\_\_\_

**Authorization Form to Request / Release Health Information:**

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.

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