New Hope Medicine

P.O. Box 7625, Kalispell, MT 59904
Telephone: (406) 393-2098
Fax: (406) 393-2097
www.newhopemt.com

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

The below named patient has requested that a copy of his/her pertinent medical records be transferred (faxed, mailed, or transported by the patient) to New Hope Medicine.

Patient Information:

Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone Number:_____

Hospital/Clinic/ Health Care Provider: (Information to be released from)

Facility Name: _____ **Phone:** _____ **Fax:** _____

Facility Name: _____ **Phone:** _____ **Fax:** _____

Facility Name: _____ **Phone:** _____ **Fax:** _____

Receiving Party: (Information to be sent to)

Name: New Hope Medicine Phone: (406) 393-2098 Fax: (406) 393-2097

Address: PO Box 7625 City: Kalispell State: MT Zip: 59904

Information to be Released:

Date Range of Medical Records: From:_____**To:**_____

_X_ Physician Progress Notes _X_ Consultations with Specialists

_X_ Radiological Reports (written only) (MRI, CT scan, Nuclear Medicine, X-rays)

___ Clinical Lab Reports ___ Electrophysiology reports (EMGs, NCSs, EEGs)

___ Other: _____

Release Instructions: ONLY SEND THE MOST RECENT TWO YEARS OF RECORDS. IF MORE THAN 30 PAGES, MAIL TO P.O. BOX 7625, Kalispell, MT 59904.

Purpose(s) or Need of Release: Continuing Care

By signing this authorization form, I understand that the information in the health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) and genetic information. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I have the right to revoke this Authorization at any time. Revocation must be in writing and presented to New Hope Medicine (fax: 406-393- 2097). Revocation will not apply to information that has already been disclosed in response to this Authorization. Requests for copies of health are subject to reproduction fees in accordance with Federal and State law. I will receive a copy of this Authorization. The above named entities may not condition treatment, payment, enrollment or eligibility for benefits on whether this Authorization is signed. Unless otherwise revoked, this Authorization will expire on the following date/event/condition:_____. If I fail to specify an expiration date/event/condition, this Authorization will expire six (6) months from the date it is signed.

_____ _____ _____

Signature of Patient or Legal Representative **Printed Name** **Date Signed**

_____ _____ _____

If signed by Legal Representative, Relationship to Patient Signature of Witness Printed Name

I hereby revoke (cancel) this Authorization to Disclose Protected Health Information:

Revocation Authorization: Cancellation Signature: _____ Date: _____