

Central Montana Eyecare PC
2012 14th ST SW
Great Falls, MT 59404
Ph (406) 452-4527 Fax (406) 453-1700

AUTHORIZATION FOR RELEASE OF INFORMATION

FULL NAME OF PATIENT: _____ DOB _____ PHONE: _____

ADDRESS: _____

PREVIOUS NAME: _____

DATE NEEDED _____ PICK UP _____ MAIL _____ FAX _____

I HEREBY AUTHORIZE (facility/provider) _____ TO RELEASE MEDICAL

INFORMATION TO (facility/provider) _____

ADDRESS: _____

USE OF MEDICAL INFORMATION _____

INFORMATION REQUESTED:

___ PROGRESS NOTES ___ CONTACT LENS INFORMATION ___ EYE EXAMINATION RECORDS
___ SPECIAL STUDIES ___ OTHER _____

DATE OF SERVICE FROM _____ TO _____

RELEASE TWELVE (12) MONTHS FROM THE DATE OF AUTHORIZATION _____

This authorization authorizes release of records prior to the date of authorization. In accordance with Montana Law 50-16-527 Central Montana Eyecare will, upon request, permit the release of the health care information relating to health care that the patient received up to twelve (12) months from the date of this authorization.

The undersigned understands that this authorization may include disclosure of alcohol, drug, mental health and HIV records which are protected by virtue of the provisions of Federal Regulations (42 C.F.R., Part 2).

This authorization shall be valid for six (6) months from the date recorded on this authorization unless otherwise specified or revoked. The undersigned understands that this authorization may be revoked at any time, upon written notification to Central Montana Eyecare, except to the extent that Central Montana Eyecare, who is to make the disclosure, has already taken action on it.

The undersigned hereby acknowledges that I have read and understand the terms and conditions of this authorization.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

Explanation if signed by other than patient (i.e., parent, legal guardian, or legal representative) _____

Notice to whoever disclosure is made: This information has been disclosed to you from records protected by Federal Regulations. These Federal Regulations prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Regulations restrict any use of this information to criminally investigate or prosecute an alcohol or drug abuse patient.