MARCUS DALY MEMORIAL HOSPITAL
Quality Care Close to Home™

Marcus Daly Memorial Hospital
1200 Westwood Drive
Hamilton, Montana 59840
(406)363-2211
www.mdmh.org

MRN: _________________

Authorization for Disclosure of Health Information

☐ I hereby authorize ____ Phone: ____________________ Fax: __________________
to disclose to **Marcus Daly Memorial Hospital Corporation and/or its associated clinics** the following information from the health records of:

☐ I hereby authorize **Marcus Daly Memorial Hospital Corporation and/or its associated clinics** to disclose the following information from the health records of:

Patient Name: ____ Date of Birth: _________________________________
First Middle Last Month Day Year

Street Address: ____

City: ______________________________ State: ___________ Zip: ___________ Phone: (____) ______________

1. This information is to be disclosed to: ☐ Self or ☐ Name: ____
Address: ____
____
Phone: (_____)________________ Fax: (_____)_______________

2. Purpose of Disclosure:
☐ Patient Request ☐ Continuing Care ☐ Other: ______________________________

3. Covering the periods of healthcare: From: __________________________ To: __________________________

4. Information to be disclosed:
☐ **Past 2 Years:** Highlights (Clinic Notes, H&Ps, Discharge Summaries, Lab Results, Radiology Reports, etc.
☐ **ALL:** Mammography + Endoscopy + Immunizations

☐ Discharge Summary
☐ History & Physical Examination
☐ Consultation Reports
☐ Operative Notes
☐ Progress Notes
☐ Emergency Room Records
☐ Radiology Reports
☐ Radiology Images on CD
☐ Cardiology Tests
☐ Laboratory/Pathology Results
☐ PT/OT/Speech Therapy Notes
☐ Home Health/Hospice Records
☐ Physician's Orders
☐ Complete Health Record
☐ Office/Clinic Notes
☐ Other (please specify): ____

5. Method of delivery:
☐ Walk-in ☐ Fax ☐ Mail ☐ Email: I understand email is not a secure method for releasing my health records. I still wish to use this as my preferred method.
Email address: ____

6. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

7. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, **this authorization will expire six (6) months from the date of signing.**

8. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

9. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management (HIM) Department Head or the Privacy Officer of Marcus Daly Memorial Hospital Corporation.

10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

____ _____________________________________
Signature of Patient or Legal Representative Date
If signed by Legal Representative, indicate relationship to the patient: ____

For Office Use Only:

Report Request ID#:
_______________________ _______________________ __________________
_______________________ _______________________ __________________

Number of Pages Released: ________
Date Completed: ________________
Released by: ___________________

MDMH # 2727517