PROVIDENCE
St. Patrick Hospital
Montana Cancer Center

Authorization for Release of Individually Identifiable Health Information to Designated Party

_____ _____ ___ _____ _____/____/_____
Patient Last Name First Name MI Date of Birth Social Security Number

This authorization grants permission to the designated party (ies) named below to all of the following: (Initial all that apply)

_____ Make or confirm appointments

_____ Verbal access to x-ray, laboratory, test findings, diagnosis, prognosis and treatment plans by telephone or other common means of communication

_____ Pick up sample medications

_____ Access to my financial health information

I hereby authorize Providence St. Patrick Hospital to use and disclose my individually identifiable health information as described above. The following are the list of people I have designated to receive my individually identifiable health information. I understand that this authorization is voluntary. I understand that once this information is disclosed to the designated party (ies) named below, the release of information may no longer be protected by federal privacy regulations. I understand an authorization for release of information will need to be signed if a photocopy of my medical record is required.

PLEASE PRINT THE INFORMATION BELOW:

Name	Relationship	Address	Telephone

I understand that this authorization will be effective for the lifetime of the patient unless revoked in writing ***OR*** it will expire on _____.

I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing; however, the revocation will have no effect on disclosures made prior to the receipt of the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization.

I authorize messages to be left on my personal answering machine regarding my protected health information. ____Yes ____No

I authorize the following person(s) to have proxy access to my records through the My Chart portal: _____

_____

_____ _____ _____
Signature of Patient Date Time

_____ _____
Printed Name of Patient's Legal Representative Relationship

_____ _____ _____
Signature of Patient's Legal Representative Date Time

Patient Label

MBA