GREAT FALLS CLINIC | PRIVIA MEDICAL GROUP

HIPAA AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient's Full Name _____ **Patient's Date of Birth** _____

Address _____ **Patient's Telephone Number** _____

City, State Zip Code _____ **Any Other Names Used** _____

I request that my provider share my Protected Health Information (PHI) as directed below. Specifically, I request that my PHI:

1. From the following Care Center locations and/or providers (list all locations):

   _____

2. Be sent to the following person / entity at the address / fax / email address listed below:

   Name _____

   Address _____ **Telephone** _____

   City _____ **State** _____ **Zip Code** _____ **Fax or Email Address for Delivery** _____

3. I hereby authorize disclosure of the following information:

   ☐ My entire medical record ☐ Immunization Records Only ☐ Service Dates Only: _____ to _____

   ☐ Specific Information Only: _____

   _____

NOTES: 1) INFORMATION ABOUT ALCOHOL/SUBSTANCE USE, HIV/AIDS AND MENTAL HEALTH ISSUES IS INCLUDED UNLESS YOU SPECIFICALLY REQUEST THAT IT BE EXCLUDED IN THE SPACE BELOW. PSYCHOTHERAPY NOTES, HOWEVER, ARE NEVER INCLUDED.

2) IF YOU REQUEST WE SEND ONLY A PORTION OF YOUR RECORDS TO A TREATING PROVIDER, WE WILL SEND YOUR RECORDS TO YOU TO GIVE TO YOUR PROVIDER; **WE WILL NOT SEND INCOMPLETE RECORDS DIRECTLY TO A TREATING PROVIDER.**

☐ **PLEASE *EXCLUDE* THE FOLLOWING INFORMATION FROM THE RECORDS SENT:** _____

_____ **Signature:** _____

4. I understand that I have the right to receive a copy of my PHI in the form, format and manner that I request, if readily producible in that way, or as I may otherwise agree. **If I do not specify a format below, I understand that my PHI will be mailed to me at the address listed above in hard copy (paper) format.**

   I hereby request that my PHI be provided in the following manner: ☐ via secure electronic delivery to the email address above; **or**

   ☐ other (please specify): _____.

5. If I have requested records be sent in an **un**encrypted format, I understand and acknowledge the risk of sending my PHI in an unsecured manner.
6. If I have requested my records be mailed to me, I understand I will be charged for the cost of paper and postage; if I request my records on a USB drive or similar device, I will be charged for the cost of that device.
7. I understand that the information disclosed may be subject to re-disclosure by the person or class of persons or entity receiving it and will then no longer be protected by federal privacy regulations.
8. I understand I may revoke this authorization by notifying my provider OR privacy@priviahealth.com in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
9. I understand that my care and treatment may not be conditioned on providing this authorization, if such conditioning is prohibited by the HIPAA Privacy Rule.
10. My purpose/use of the information is for : ☐ personal use; or ☐ other (please specify) _____.
11. This authorization expires on _____ ____, 20____, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: (please describe/specify event). If no expiration date is provided, this authorization will expire on one year from the date signed.

    _____.

NOTE: FEES FOR COPIES: When a patient requests a copy of his/her PHI for personal use, federal law permits a reasonable, cost-based fee that includes only labor for copying the PHI, costs for supplies, labor for creating a summary/explanation of the PHI if a summary or explanation was requested, and postage. If these charges are expected to exceed $25, we will attempt to inform you prior to your request being filled.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING; INCOMPLETE FORMS WILL NOT BE PROCESSED.

_____	_____	_____
Signature of Patient	**Date of Patient's Signature**	**Patient's Date of Birth**
_____	_____	_____
If Patient unable to sign, signature of Patient's Legal Guardian or Personal Representative of Patient's Estate	**Date of Legal Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**