MONTANA STATE VETERANS' HOME

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

PHONE: (406) 892-3256
FAX: (406) 892-0256

400 VETERANS DRIVE
PO BOX 250
COLUMBIA FALLS MT 59912-0250

AUTHORIZATION
For the Use and Disclosure of Health Information

Federal law says that we cannot share your health information without your permission except in certain situations. If you sign this form, you are giving us permission to share the health information you indicate below. This does not keep the information from being shared with more people once it leaves our office. This authorization will only last until the date you specify, but not longer than one year.
If you decide later that you do not want us to share your information any more, you can sign the REVOCATION SECTION at the end of this form and return it to us.

Date:_____

Person or Group Needing the Health Information: ___MONTANA STATE VETERANS HOME_____

I give permission to _____, to share the health information checked below with the person or group listed above:

- ☐ All Information
- ☐ Information from a certain time period (specify dates):

  From_____ To_____
- ☐ All information relating to a certain event or injury – example: left knee injury from December 2000 (specify event and dates):

  Event_____

  Date of event_____
- ☐ Other (specify):_____

Purpose of Disclosure for admission to the Montana State Veterans Home

The medical record includes all health care information, whether oral or recorded in any form or medium that identifies the patient or can readily be associated with the patient and relates to the patient's care. This includes all health care information in your/our possession, whether generated by you/us or any other source, as well as health care information associated with drug/alcohol abuse, mental or psychiatric care, abortion, and HIV status and/or diagnosis of AIDS and/or other sexually transmitted diseases including hepatitis.

If one of the above facilities is requesting this authorization be completed, an individual has the right not to sign with the understanding that an individual's health care and the payment for health care will not be affected.

I understand that this authorization may be revoked by me at any time, provided that I do so in writing and submit it to the Medical Records Department up to the extent that the disclosure has not already been made. I also understand that my protected health information may be redisclosed by the recipient and no longer be protected under federal law. Authorization will expire in 6 months unless otherwise specified below

Printed Name:_____Signature_____

Signature of Authorized Representative_____ Date_____

Relationship of Authorized Representative_____

REVOCATION SECTION
I no longer want my information shared.

Signature_____ Date_____

HIPPA AUTHORIZATION

SS#_____

DOB_____