CARDIOVASCULAR CONSULTANTS OF MONTANA

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Authorization for CardioVascular Consultants of Montana Use or Disclosure of Protected Health Information

Patient Name:_____ Date of Birth:_____

Address:_____

SSN: _____Telephone Number _____

I request and authorize _____to release health care information of the above named patient to:

☐ **CardioVascular Consultants of Montana**
1101 North 27th Street Suite F
Billings, MT 59101-0101

☐ _____
_____
_____

Purpose for release of information: ☐ Continuing patient care ☐ Personal

Responses to requests will contain a records abstract of three (3) most recent years from the last date of service. This will include:

- For clinic records – Provider Notes, Operative/Procedure Reports, and Test/Lab Results
- For hospital records – History and Physical, Discharge Summary, Operative/Procedure Reports, Emergency Department Reports, Consultation Reports, and Test/Lab Results

I understand this authorization covers records relating to communicable diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral and/or mental health care, alcohol and/or drug abuse treatment, medication history, and genetic testing, if any such records exist.

I understand that CardioVascular Consultants of Montana will not condition treatment on whether I sign this Authorization.

I understand that I have the right to revoke this authorization at any time except to the extent that CardioVascular Consultants of Montana has already taken action in reliance on it. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to: CardioVascular Consultants of Montana, 1101 North 27th Street Suite F, Billings, MT 59101-0101. I understand that the revocation will not apply to information that has already been released in response to this Authorization.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be re-disclosed by the person or entity that receives the information.

I understand that this authorization will expire one (1) year from the date of signing.

_____ _____
Signature Date

_____ _____
Print Name Relationship to Patient (if not patient)