Bridger
EAR, NOSE & THROAT
Brennan T. Dodson, MD

Medical Records Release

Authorization for Use and Disclosure of Protected Health Information

Patient Legal Name _____ Date of Birth _____

Address _____ Phone _____

City _____ State _____ Zip _____

Release Records From:	***Release Records To:***
Name _____	Name _____
Address _____	Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Phone _____ Fax _____	Phone _____ Fax _____

Purpose:	***Information Authorized for Disclosure:***
☐Continuation of Care ☐Insurance ☐Personal ☐Litigation ☐Other: _____	☐Specific Item(s) _____ ☐ Specific Date(s) _____ ☐ Entire Record

I authorize (name a person): _____to pick up my Protected Health Information.

I hereby authorize Bridger Ear, Nose & Throat to use and disclose the specific protected health information described above to the recipient for the purposes outlined above.

I understand that:

- The designated record set may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral and mental health services, child abuse, or alcohol/drug abuse treatment.
- Revocation will not apply to information already disclosed with this authorization for disclosure or information disclosed for purposes of treatment, payment or health care operations.
- I can revoke this authorization at any time by sending a written statement to: Bridger Ear, Nose & Throat, 1648 Ellis St. Ste. 301, Bozeman, MT 59715.
- Fees/charges will comply with all laws and regulations applicable to release of information.
- Authorized disclosure of information may be subject to unauthorized re-disclosure.
- Refusal to sign this authorization will not affect treatment.
- I have a right to receive a copy of this authorization.
- If I am signing for a child under 18 years old, I am the legal parent/custodial parent and have the right to make all medical decisions for this child.
- This authorization expires in one year.
- I have read this authorization and I understand it.

_____ _____

Print Name of Patient/Patient Representative | Relationship to Patient

_____ _____

Signature of Patient/Patient Representative | Date

Office Use Only
☐ Date Released_____ ☐ Item(s) Released _____ ☐ Mailed or Faxed _____ ☐ Staff Initials _____