# DANIELS MEMORIAL HEALTHCARE CENTER

**"Committed to providing excellence in rural community healthcare"**

**P.O. Box 400 – 105 5th Ave. E – Scobey, Montana 59263**
**Phone 406-487-2296 – Fax 406-487-2471**

Requesting Records from (Provider/Facility):_____

Records to Be Disclosed and Sent To: _____

Address: _____ Phone: _____ Fax: _____

Name of Patient: _____ Phone _____

Date of Birth: _____ Social Security #: _____

I authorize the use of disclosure of the above named patient's private health care information as described below. (Please Check)

- ☐ Hospital Notes
- ☐ Clinic Notes
- ☐ Consultations
- ☐ Laboratory Reports
- ☐ EKG Reports
- ☐ Radiology Reports
- ☐ Radiology Films
- ☐ ER Notes
- ☐ Complete chart
- ☐ Other (please specify) _____

Date(s) from: _____To: _____

This information is needed for the purpose of _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Record Department. I understand that the authorization is subject to revocation at any time except to the extent that the program or person, which is to make the disclosure, has already acted in reliance on it. Acting in reliance includes the provision of treatment or services in reliance on a valid consent to disclose information to a third party payer.

**Unless otherwise revoked this authorization will expire on the following date, event, or condition:**

_____

**(If I fail to specify an expiration date, event or condition, this authorization will expire in six months.)**

There will be a $15.00 research & retrieval fee, plus a fee of $0.50 per page, if I request these records for my own personal use.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

If I have any questions about disclosure of my health information, I can contact the Daniels Memorial Healthcare Center Medical Record Department.

_____ _____

Signature of Patient or Legal Representative Date of Signature

If signed by Legal Representative, relationship to patient _____