

# Records Release



## Patient Authorization for Use & Disclosure of Protected Health Information

By signing this authorization, I \_\_\_\_\_ authorize the following;

Name: \_\_\_\_\_ Address/Phone/Fax: \_\_\_\_\_

To release my medical records to Name: \_\_\_\_\_

Address/Phone/Fax: \_\_\_\_\_

This authorization permits the above mentioned to use and/or disclose the following individual health information about me (specifically describe the information to be used or disclosed):

- Complete health record(s)
- Progress notes
- Consultation reports
- Pathology
- Other (please specify) \_\_\_\_\_

From (date): \_\_\_\_\_ to \_\_\_\_\_

Unless otherwise cancelled, this authorization will expire 12 months.

### **I DO NOT HAVE TO SIGN THIS AUTHORIZATION IN ORDER TO RECEIVE TREATMENT FROM Philip Tallman MD PC**

In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to Philip Tallman, MD, PC, 2294 Grant Rd, Billings, MT 59102

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Print Name of Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date