6/2019

Missoula City-County Health Department
IMMUNIZATION SERVICES
301 W Alder Street| Missoula, MT 59802-4123
PHONE | 406.258.3363
406.258.4292
FAX | 406.258.4913

AUTHORIZATION FOR THE 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 prevent the information from being re-shared by the recipients.

Client Name:_____ Date of Birth:_____/_____/_____

Other Name(s) Used/Maiden Name:_____ Phone:_____

Option 1: Missoula City-County Health Department (MCCHD) RELEASE OF INFORMATION

TO: ____ I am requesting a copy of my own records **OR** _____Individual/Organization:_____
Fax:_____ Phone:_____
Address:_____
City:_____
State:_____ Zip:_____

Purpose: (Please check one) _____Client Request _____Co-Management with a Specialty Provider _____Continuation of Care
_____Other: _____

I am requesting the following protected health information to be released from MCCHD: (Must initial those that apply)
_____Immunization Records _____ Travel Clinic Medical Records _____ Chest X-Ray Results _____Tuberculosis Screening/Treatment
_____Laboratory Results _____Home Visiting Records _____Other:_____
Specific Date(s):_____ to _____ Specific Information only:_____

Option 2: Missoula City-County Health Department (MCCHD) REQUESTS INFORMATION

FROM: Individual/Organization:_____ Fax:_____ Phone: _____
Address:_____ City:_____ State:_____ Zip:_____

Purpose: (Please check one) _____Client Request _____Co-Management with a Specialty Provider _____Continuation of Care
_____Other: _____

I am requesting the following protected health information to be released to MCCHD: (Must initial those that apply)
_____Clinic Medical Records _____Hospital Records _____Dental Records _____Psychiatric/Counselor ____Therapist
_____Pathology Records _____Immunization Records _____Laboratory records _____Imaging Records (X-Rays, CT, MRI etc)
_____Tuberculosis Screening/Treatment _____Specific Date(s):_____ to _____
_____Specialist:_____ _____Specific Information only:_____
_____Other:_____

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Unless otherwise revoked, this authorization will expire one year after it is signed. By signing this authorization, I acknowledge that:

- My record may contain information regarding the screening for HIV (human immunodeficiency virus), other bloodborne pathogens (Hepatitis B, Hepatitis C), or sexually transmitted diseases. I give my specific authorization for these records to be released.
- Only records maintained by Missoula City-County Health Department will be released.
- With written consent on file, immunization records from the State Registry imMTrax, also can be released.
- I have the right to revoke this authorization at any time. Revocation must be done in writing. I understand that I cannot revoke an authorization for information that has already been released in response to this authorization.
- This authorization is voluntary. I can refuse to sign this authorization. I need not sign this authorization to receive treatment, payment for services, enrollment or eligibility for benefits.
- I may inspect or copy this authorization provided in 45 CFR 164.524. I understand that any disclosure of information under this authorization carries with it the potential for an unauthorized re-disclosure by the recipient and, after it is disclosed, the information may not be protected by state or federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Missoula City-County Health Department Health Services Division Director.

Client/Authorized Representative* Signature_____Date:_____/_____/_____

***Parent, Legal Guardian, or Legal Representative. Supporting legal documentation must accompany this form when services are requested by the client's Legal Guardian or Legal Representative.**

Please Print Your Name: _____Relationship to Client:_____

Witness signature (only required for mental health records):_____