UNIVERSITY OF MONTANA
CURRY HEALTH CENTER

634 Eddy Ave.
Missoula, MT 59812
Phone: 406-243-2122
Medical Records Fax: 406-243-6949

Authorization For The Release of Health Information

Student Information

Name: _____ Date of Birth: _____

Student ID#: _____ Phone #: _____

Address: _____
Street City State Zip

Last Date Attended U of M: _____ Previous Names: _____

Who has the information you need?

I Authorize _____ at Curry Health Center to:
Name of Provider

☐ Release health information -> **TO:** ☐ Request health information -> **FROM:**

Where do you want the information sent/received?

Name: _____

Agency Name: _____

Address: _____
Street City State Zip

Phone: _____ Fax: _____

Method of Release

(choose ONLY one)

☐ Mailed ☐ Faxed
☐ Picked Up ☐ Verbal Release

Information to be sent (check all that apply)

Information to be Released/Received

☐ All health information in my medical record, to include x-ray and laboratory
☐ Pap / Annual Exam (most recent) ☐ Insurance
☐ Immunizations ☐ Dental Treatment Summary
☐ Billing ☐ Dental x-ray
☐ Other requests or limitations: _____

These records require a specific consent to release - initial if requesting one of the following:

_____ Psychological Test reports (i.e. ADHD report, etc.) _____ Behavioral Health Options *
_____ Psychiatric Treatment _____ Counseling Summary (dates, provider, diagnosis, course of treatment)
_____ All Counseling notes (detailed notes, may include highly personal information)

Purpose of Disclosure

☐ Personal use ☐ Continuity/Coordination of Care ☐ Academic ☐ Insurance
☐ Legal ☐ Other:_____

If one of the above facilities is requesting that this authorization be completed, an individual has the right not to sign with the understanding that an individual's health care and the payment for health care will not be affected. I understand that this authorization may be revoked by me at any time, provided that I do so in writing and submit it to the Health Records Department, up to the extent that the disclosure has not already been made. I also understand that my protected health information may be re-disclosed by the recipient and no longer protected under federal law. Authorization will expire in **6 months** from my signature, **or a lesser period of time** as specified here: _____

_____ _____
Student Signature OR Legal Representative/Guardian **Date**

Relationship to patient:_____

Legal representative/guardian must present supporting legal documentation and description of person's authority.

* This information has been disclosed to you from confidential records, which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR, Part 2) prohibits you from making any further disclosure of this information unless disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.