# Four Corners Health Care, Inc.

**7720 Shedhorn Dr., Suite D**
**Bozeman, MT 59718-8108**

## AUTHORIZATION FOR USES & DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

**Patient Information (please print):**

Name:________________________________Former Name:______________________

Date of birth: _____________________ Phone: (_________)_______________________

Address:________________________________________________________________

City:________________________________State:_________Zip:__________________

**I request health information be sent**

**From:** ___________________________

Address: ___________________________

__________________________________

__________________________________

Phone #:_____________Fax:____________

**To:** ________________________________

Address: ____________________________

_______________________________________

_______________________________________

Phone #: _______________Fax:____________

**Information to be disclosed (check as appropriate):**

___office visit notes ___lab results ___immunization record

___imaging reports (xray, MRI, CT scans, mammograms, etc)

___other: Please specify:_____________________________________

**Purpose of information disclosure (check as appropriate):**

___transfer of health care ___specialist care ___personal use

___other: Please specify: _____________________________________

***By signing this release form, I understand:***

- Information disclosed may include mental health, sexual, or other sensitive information.
- Any disclosure of information has the potential for re-disclosure and information then may not be protected by federal confidentiality rules.
- I may cancel this authorization at any time, otherwise this release will expire 6 months after the date signed. Cancellation does not apply to information already released.
- This authorization is voluntary. Treatment, payment, enrollment, or eligibility for benefits will not be affected by my signing this authorization.
- I have a right to request a copy of this authorization.
- I may request to inspect or obtain a copy of the disclosed information.
- Fees may be charged for photocopying or mailing services.

____________________________________ ___________________________

Signature (parent/guardian if for minor) Date