FALLON MEDICAL COMPLEX

"Friends Healing Friends"

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Baker, MT 59313-0820
(406) 778-3331
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Verbal Release of Information

❑ **Fallon Medical Complex** ❑ **Community Clinic** ☐ **Physical Therapy** ☐ **Long-Term Care**

Patient Name:	**Birth Date:**
Address:	**City:**
State:	**Zip Code:**

Medical Record Number at Fallon Medical Complex:

The undersigned hereby authorizes and requests ❑ **Fallon Medical Complex** and/or ❑ **Community Clinic** to verbally release health information to:

Reason:

Name of Individual(s)	**Relationship**

I hereby authorize verbal release of health information pertaining to ❑ Laboratory Reports ❑ X-ray/EKG Reports ❑ Clinic Visits (physician progress notes) ❑ ER Visits ❑ Observation Stays ❑ Inpatient/Skilled Swingbed Stays to the above mentioned individual(s).

❑ No limitations placed on dates, history of illness, or diagnostic and/or therapeutic information, **INCLUDING any treatment for**
❑ **alcohol** ❑ **drug abuse** ❑ **mental health records** ❑ **HIV testing or treatment of AIDS or AIDS related conditions**
Signer must initial for authentication of this response Init. _____

❑ No limitations placed on dates, history of illness, or diagnostic and/or therapeutic information, **EXCLUDING any treatment for**
❑ **alcohol** ❑ **drug abuse** ❑ **mental health records** ❑ **HIV testing or treatment of AIDS or AIDS related conditions**
Signer must initial for authentication of this response Init. _____

RELEASE CAN ONLY COVER A PERIOD NOT TO EXCEED ONE YEAR

This authorization covers the period of _____ ,20_____ to _____, 20_____. I also understand this authorization does not allow release of copies of any records to the above mentioned individual(s) and a request for release of records requires a separate release.

Signature:	**Date:**
If signed by personal representative, state relationship & authority to do so:	
Witness:	**Date:**

- ***This authorization expires one (1) year from the date of signature.***
- ***This authorization may be revoked at any time by submitting request in writing to the above address.***
- ***The disclosed information above may, in some instances, be re-disclosed by the individual/entity receiving the information In these instances the disclosed information is no longer protected by the HIPAA Privacy Rule and FMC is not responsible for its disclosure***
- ***FMC/Community Clinic will not condition treatment, payment, continued enrollment in a health plan, or eligibility for benefits based on the individual providing appropriate authorization.***
- ***The above individual(patient/resident/legal representative) may inspect or copy protected health information to be used or disclosed as provided in §164.524 of the Privacy Act.***
- ***A third party will compensate FMC directly or indirectly when disclosure will result in such compensation.***