AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name of Patient ("Patient"): _____

Patient's Social Security No.: _____

Patient's Date of Birth: _____

Patient's Address (No PO Box): _____

City, State, and Zip Code: _____

Phone Number: _____

I hereby authorize **Advanced Care Hospital of Montana** (the "Hospital") to use and disclose protected health information related to the Patient, as follows:

1. Information to be Used and Disclosed. The following information relating to the Patient may be used or disclosed for the purposes described below:

   ☐ Complete medical records, ☐ HIV Testing Results ☐ Psychiatric or Psychological Records

   ☐ Alcohol or Drug Abuse Treatment Records

   ☐ H & P ☐ Discharge Summary ☐ MARs ☐ Labs ☐ X-Rays, MRI, CT Scan

   ☐ Other: _____ (specify)

2. Please specify admission or dates of treatment: From _____ (date) to _____ (date)

3 I understand that the records identified above may include information relating to Human Immunodeficiency Virus ("HIV") infection or Acquired Immune Deficiency Syndrome ("AIDS"); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.

4 Recipients of Information. I understand that the information described above will be used by the Hospital and disclosed to:

Name of Recipient: _____
Address: _____
City, State, and Zip Code: _____
Phone number: _____

5 Purposes of Authorization. I understand that this authorization is being obtained for the following purposes:

_____

(*include a description of each purpose of the authorization*).

6 Marketing. One purpose of this authorization is marketing activities. The marketing may involve direct or indirect remuneration, or payment, to the Hospital from a third party.

7 Re-Disclosure. I understand that to the extent any Recipient of this information, as identified above, is not a "covered entity" under Federal or state privacy law, the information may no longer be protected by Federal or state privacy law once it is disclosed to the Recipient and, therefore, may be subject to re-disclosure by the Recipient.

8 Revocation. I understand that I may revoke, or cancel, this authorization at any time except to the extent that the Hospital has already relied on the authorization. I understand that I may revoke this authorization by sending a written notice stating my intent to revoke this authorization to the Hospital's Privacy Officer

9 Expiration Date or Event. This authorization is valid for six months, unless earlier revoked in writing as indicated above.

10 Withholding Treatment. I understand that the Hospital may not withhold treatment from me as a condition of completing this authorization form. However, I understand that the Hospital may withhold research-related treatment from me as a condition of completing this authorization form, or may withhold the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party as a condition of completing this authorization form.

Signature of Patient or Legally Authorized Representative: _____ DATE: _____

Printed Name of Patient or Representative: _____