Helton Hearing Care
understand. connect. live.

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RECORDS RELEASE

THIS FORM MUST BE COMPLETED IN THE ENTIRETY BY THE PATIENT OR THE PATIENT'S AUTHORIZED REPRESENTATIVE

1. **Patient Information:** First Name: _____ Last Name: _____
   Date of Birth: _____ Phone Number: _____
   Address: _____
   I, the above-referenced patient, hereby acknowledge and give authorization for the release and disclosure of medical records and/billing information as follows:

2. **Records to be received from**: Organization / Individual Name: _____
   Phone Number: _____ Fax Number: _____

3. **Records to be sent to:** Organization / Individual Name: _____
   Address: _____
   Phone Number: _____ Fax Number: _____

4. **Type of information to be released:**
   - **A. Medical Records:**
     - ☐ I want the following parts of my medical record to be disclosed:
       Dates of Service: FROM _____ TO _____
       - ☐ Evaluations ☐ Reports
       - ☐ Consultation Reports from (Dr.'s Name)_____
   - **B. Billing Records:**
     - ☐ **Dates of Service:** FROM _____ TO _____

5. I understand I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six (6) months, according to Montana Law. I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Helton Hearing Services privacy officer.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, relationship to patient, or reason for signing Date

YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN.
Please note that there may be a charge to copy records.