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: _____ Social Security Number: _____ 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. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

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

3. **Records to be sent to:** Organization / Individual Name: _____
   Phone Number: _____ Fax Number: _____
   Address: _____
   HIPAA allows records to be faxed to the medical facility of your choice. Any physical records may either be picked up in person, or they must be shipped by FedEx / UPS with a signature upon delivery. Shipping charges for physical copies are a separate expense and must be paid in full prior to shipping. There is a minimum $20 charge for copying records and administrative fee, which includes up to the first 40 pages with an additional 50 cents per page beyond that. Please allow up to 48 hours for us to process your records request.

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.