



**General Medical Records Release and  
Authorization for Use or Disclosure of Protected Health Information**

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

I authorize the custodian of records of: or other person/entity (specifically describe) to disclose/release the following information\* (check all applicable):

- |   |  |
|---|--|
| <input type="checkbox"/> All records                  | <input type="checkbox"/> Abstract/Summary              |
| <input type="checkbox"/> Laboratory/pathology records | <input type="checkbox"/> Pharmacy/prescription records |
| <input type="checkbox"/> Billing Records              | <input type="checkbox"/> Other (describe specifically) |
| <input type="checkbox"/> X-ray/radiology records      | _____  |

These records are for the services provided by CarePlus+ on \_\_\_\_\_ (date.)

**Please send the records listed above to:**

CarePlus+ Alternative Health Clinic  
Phone: (800) 210-0012  
Fax: (804) 518-4938 or (406) 207-3395  
Address: PO Box 8282, Missoula, MT 59807

The information may be disclosed for each of the following purposes:

- |  |  |
|--|--|
| <input type="checkbox"/> At my request (only the patient can check this box) | <input type="checkbox"/> For payment/insurance   |
| <input type="checkbox"/> For my health care                                  | <input type="checkbox"/> For employment purposes |
|  | <input type="checkbox"/> Other: _____            |

This authorization shall expire no later than: 01/01/2018, and may not be valid for greater than seven (7) years from the date of signature for medical records. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to the Privacy Liaison, 3800 Reservoir Road, N.W. Washington, DC 20007.*

*A copy of this signed authorization can be given to the above mentioned individual upon request.*

*If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*