Sapphire Community Health (SCH)
316 N. 3rd Street
Hamilton, MT 59840

Phone: 406-541-0032 Fax: 406-541-0036

Provider _____ PSR_____

# Request of Records

**Use this form to request records from the past 2 years.**

**PLEASE PRINT LEGIBLY**

Patient Name: _____ Date of Birth: _____

Other Name (s) Used / Maiden Name:_____ Phone Number: _____

Address _____ City, State, Zip _____

Who is your provider Sapphire Community Health?_____ Are you established with us? Y N

**REQUEST** A COPY OF MY PROTECTED HEALTH INFORMATION FROM:

**Physician/Facility/Entity**: _____ Phone: _____

**Address:** _____ Fax: _____

**City:** _____ State: _____ Zip: _____

Purpose for requesting information: (Please check one) _____Patient Request _____ Other _____ Continuation of Care

I am requesting the following of my protected health information to be released to SCH: **(Must INITIAL all that apply)**

_____ Clinic Medical Records _____ Immunization Records _____ Imaging Records (X-Rays, MRIs, CT Scans, etc.)

_____ Laboratory Records _____ Pathology Records _____ Immunizations

_____ Psychiatric/Behavioral Health Records _____ Substance Abuse Records _____ HIV/AIDS related information

_____ Specific Information only (list): _____

Please send medical records for prior two (2) years.

**By signing this authorization, I understand that:**

**a**. My records may contain information regarding the diagnosis or treatment of AIDS (acquired immunodeficiency syndrome) or infection with HIV(human immunodeficiency virus), substance abuse (drugs and/or alcohol), psychiatric/psychological or mental health care, or sexually transmitted diseases. I give my specific authorization for these records to be released.

**b.** I have the right to revoke this authorization at any time. Revocation must be done in writing. I understand that I cannot revoke an authorization for information that has already been released in response to this authorization.

**c.** This authorization is voluntary. I can refuse to sign this authorization. I need not sign this authorization to receive treatment, payment for services, enrollment or eligibility for benefits.

**d.** I may inspect or copy this authorization provided in 45 CRF 164.524. I understand that any disclosure of information under this authorization carries with it the potential for an unauthorized re-disclosure by the recipient and, after it is disclosed, the information may not be protected by state or federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Sapphire Community Health Medical Records Department.

**e.** I understand that my drug and/or alcohol treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and my health information is protected C.F.R. Part 160 and 164. My information cannot be disclosed without my written authorization unless otherwise provided for the regulation.by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45

Method of disclosure: ☐ Phone ☐ Mail ☐ e-share ☐ fax ☐ in person ☐ Other _____

_____ _____

Patient / Authorized Representatives Signature Date ( Expires 1 yr date of signature)

_____

Printed name and relation