AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
To The Montana Medical Legal Panel

To:

Provider Name	**Mailing Address**	**City**	**State**	**Zip Code**

Patient Identifying Information:
Name:_____ Date of Birth:_____
Address : _____ Social Security Number :_____

Dates of Care Re ndered : From_____to_____
(ONLY DISCLOSE RECORDS WITHIN THE DATES OF TREATMENT INDICATED ABOVE.)

The undersigned hereby authorizes the release of the above-named Patient's health information by the above-named health care provider to the Montana Medical Legal Panel (the "Panel") as follows :

> **ALL medical records and information in Health Care Provider's possession related to the Patient's health care, whether generated by you or by any other health care provider, including but not limited to providers' notes, orders, diagnostic studies (radiology, laboratory, EKG, etc.), x-ray films, histories, examinations, treatment records, summaries, hospital records, nurses' documentation, prescriptions, telephone messages, consultations, mental health records, psychiatric and psychological evaluations, diagnostic testing, raw test data, reports, correspondence and medical bills.**

The undersigned specifically authorizes the release of the following categories of health information, unless the line next to the in form ation is checked to indicate the information should not be disclosed *(Pl ease initial where disclosure* is *not authorized):*

do not disclose records of HIV/AIDS/STD testing or treatment.
do not disclose mental, psychological or psychiatric records.
do not disclose psychotherapy notes as defined by the HIPAA Privacy Standards, 42 CFR Part§ 164.508(a)(2)
do not disclose alcohol and/or drug abuse treatment records.
Other restrictions on disclosure (specify):_____

I understand that this authorization is valid for a period of 24 months from the date of the signature below or upon the rendering of a final decision on the Claim by the Panel, whichever is sooner, unless it is revoked earlier as provided below. understand this authorization is not valid without the required signature. I understand I *have* the right to *revoke* this authorization at any time in writing, except to the extent that a provider or practitioner has already disclosed records or information to the Montana Medical Legal Panel.

I understand that the information that is disclosed pursuant to this Authorization may be subject to redisclosure by the Montana Medical Legal Panel as is allowed and or required by applicable law, and, therefore, it may no longer be protected by the HIPAA Privacy Standards . I also understand that by authorizing the disclosure of the health information described herein that I am waiving my right to privacy to that health information for purposes of consideration of my Claim by the Panel. Nothing herein, *however,* shall be construed as waiving my rights to privacy to the disclosed health information for any other purpose or in any other context, nor is this authorization intended to provide for discovery of information that would be privileged pursuant to Rule 26(b)(4)(8), Montana Rules of *Civil* Procedure.

I understand that, in general, treatment, payment, enrollment or eligibility benefits may not be conditioned on whether or not I sign this authorization. I understand I do not *have* to sign this authorization; *however,* I also understand that if I do not sign it, my Claim may not be heard by the Panel and may be subject to dismissal.

Print Full Name	Signature	Date

AUTHORITY TO SIGN ON BEHALF OF PATIENT:
Please check applicable box if signing on behalf of patient and provide a copy of authorizing document for items marked below with an asterisk(*).

□Parent of Minor Child □Le gal Guardian * □Power of Attorney* □Oth er Personal Representative Designation*