Sheridan Memorial Hospital Association

440 West Laurel Avenue Plentywood, MT 59254 Phone (406) 765-3700 Fax (406) 765-3756

Medical Records:
The Health Information Management Department (HIM), also known as Medical Records, maintains the medical records for patients receiving care at Sheridan Memorial Hospital Association.

Contact Information:
Health Information Management Department
(406) 765-3711
Fax
(406)765-3756

Mailing address for Release of Information:
HIM Department
Sheridan Memorial Hospital Association
440 West Laurel Ave
Plentywood, MT 59254

Office Hours:
Monday – Friday: 8:00 a.m. – 5:00 p.m.

How Do I Obtain or Transfer Copies of My Medical Records?
Patients and/or their legal representatives may inspect and/or obtain a copy of their personal health information.

Sheridan Memorial Hospital Association requires a completed and signed authorization form to release health information to anyone, including the patient. In certain cases, a patient's physician may also be required to approve a request before releasing the health information.

To obtain a copy or transfer your medical records, please complete our Authorization for Release of Patient Identifiable Health Information form.

- The authorization must be signed by the patient (must be at least 18 years of age), a parent of a minor, or the patient's legal representative. Legally emancipated minors may sign for their own records.
- The form must be as complete as possible. Please mark what information you wish to have released such as specific dates.
- If you need radiology films transferred to another health care provider, please indicate this on the form as well. We will forward your request to our Radiology Department.
- Please mail or fax your signed, completed authorization to:
    - Health Information Management
      Sheridan Memorial Hospital Association
      440 West Laurel Avenue
      Plentywood, MT 59254
      Fax (406) 765-3756
- You may also bring your completed authorization form directly to the HIM Department during our office hours. Depending on the number of pages to be copied, we may ask you to return at a later time to pick up.

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Authorization for Release of Patient-Identifiable Health Information

Authorization to Disclose Health Information

Patient Name: _____ Health Record Number: _____

Date of Birth: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:
   _Sheridan Memorial Hospital Association_____
   Address __440 West Laurel Plentywood, MT 59254_____
3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

☐ Medication list
☐ History and physical
☐ Laboratory results
from (date) _____ to (date) _____
☐ Consultation reports
from (doctors' names) _____
☐ Other_____

☐ Progress Notes
☐ Discharge summary
☐ X-ray reports
from (date) _____ to (date) _____
☐ Entire record
☐ Operative Report

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual or organization:
   _____
   Address: _____
   for the purpose of _____.
6. I understand that 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 and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in (six month, one year, as applicable to your state law or facility guidelines).
7. I understand that 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 that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that 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 the Privacy Officer of Sheridan Memorial Hospital Association.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to Patient Signature of Witness