650 Rainbow Trout Run
PO Box 160382
Big Sky, MT 59716
406.995.2100
www.bigskyfire.org

Big Sky Fire Dept
Patient Request for Access Form

Patient Name: _____ Date: _____
Address:_____
City: _____ State_____ Zip Code: _____
Social Security Number: _____ Last Date of Service: _____
Reason for Request: _____

Patient Rights: As a patient, you have the right to access, copy or inspect your protected health information, or PHI, in accordance with federal Jaw. You may also have the right to request an amendment to your PHI, or request that we restrict the use and disclosure of it. These rights are further described in our Notice of Privacy Practices and in other policies which you may have upon request.

READ THE FOLLOWING PRIOR TO SIGNATURE

The original medical record is the property of Big Sky Fire Dept.
Medical records sent from another facility cannot be released.
There is a minimum 10 day waiting period.
I authorize any doctor, health care provider, hospital, clinic or medically related facility to release any personal information; including, physical, mental, drug, or alcohol use, sexually transmitted diseases, including HIV history.
I understand that this information is protected by Federal law and cannot be released without this consent.
I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any affect on any actions they took before the received revocation.
You may refuse to sign this authorization.

You specifically have my permission to release this information.

_____ _____
Signature Date

_____
Printed Name

Request: ☐ Approved ☐ Denied

By: _____ Date: _____