**What this form does:** gives us your permission to exchange info on your prescriptions with a large, secure national database. This is meant to make sure our records are as accurate as possible to provide you with safer, better quality care.

## AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form.

In accordance with Montana State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

Beargrass Family Medicine, PLLC uses SureScripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my primary care office and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized by Beargrass Family Medicine, PLLC to help ensure safe prescribing and high quality care.

This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc. to Beargrass Family Medicine, PLLC.

I have the right to revoke this authorization at any time by writing to Beargrass Family Medicine, PLLC. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law. This authorization does not authorize Beargrass Family Medicine, PLLC, to discuss my health information or medical care with anyone other than those permitted under applicable law.

This authorization expires one year from the date of my signature below.

Patient name: _____

Patient birth date: _____ Today's date: _____

Patient / legally authorized representative signature:

_____

Relationship to patient (if applicable):

_____