Elevated Echo

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RELEASE OF INFORMATION

Authorization to Release Protected Health Information

Release Authorization

I authorize Elevated Echo to release my echocardiogram report and related records to the physician who ordered this test for purposes of continued care.

If I would also like the report sent to another provider, I can list them below. This section is optional — leaving it blank does not affect the release to my ordering physician.

Additional Recipient — Provider / Practice Name _____ Fax or Secure Email _____

What I Understand

- My records are protected by HIPAA and Montana law (MCA § 50-16-527).
- This authorization is voluntary, and refusing to sign will not affect my ability to receive care at Elevated Echo.
- Unless I specify otherwise, this authorization expires 6 months from the date signed. Under Montana law, it applies only to care received within 6 months of signing.
- I may revoke this authorization in writing at any time, except to the extent information has already been released.
- Once released, information shared with a non-covered recipient may no longer be protected by HIPAA.
- A legal representative signing on my behalf must attach proof of authority (power of attorney, guardianship, or parental status).

Patient Information

Patient Name (printed) _____

Patient Signature (or legal representative) _____ Date _____