301 Saddle Drive Helena, MT 59601
P 406.422.5905 **F** 406.422.5425

Authorization to Release Medical Records

Name of Patient_____ Date(s) of Service_____
Date of Birth_____ Social Security Number_____
I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

PATIENT INFORMATION IS NEEDED FOR:
Continue Medical Care Consultation Report Emergency Room Record
Operative Reports Discharge/Death Summary Face Sheet
Lab/Path Reports X-Ray Reports/Images Other:_____
The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):
TO:

_____
(Doctor, Hospital, Attorney, Insurance Company, Self, Etc.) Phone Number:

_____
Address (Street, City, State and ZIP)
FROM:

_____
(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number:

_____
Address (Street, City, State, and ZIP)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I Understand that I may revoke this authorization in writing at any time except to the extent that action has been taken reliance upon the authorization.

The authorization will expire (6) months from the date of my signature, unless I revoke the authorization prior to that time

Date:_____Signature: _____
Patient or Legally Authorized

_____
Printed Name of Patient or Legally Authorized Representative