**HELENA ORTHOPAEDIC CLINIC**
**2442 WINNE AVENUE SUITE #1**
**HELENA, MT 59601**
**PHONE: (406) 457-4100 FAX: (406) 457-4102**

# AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

_____ _____ _____
Name of Patient (Please Print) Date of Birth Social Security Number

## INFORMATION TO BE RELEASED TO OR PICKED UP BY:

_____
Full Name and Title; Hospital, Agency, Physician, etc.

_____
Mailing Address City State Zip

_____ _____
Phone Fax

## The information to be release is to be used for the purpose of:

Continuity of Care
Workers' Compensation Claim
Disability Determination
Attorney
Personal Records
Other: _____
Insurance Claim
Military Records

## I request release of the following information – please mark all that apply

Office notes
Operative reports
Billing Statements
MRI, Bone Scan, EMG, CT scan (Reports)
Labs
X-rays of:_____
Medical Condition Status Report
Work Status Report
Access to any and all information
Prescription Pickup
Discussion with Physician/phone calls
No records requested at this time

## I would like my records sent by: (Please Circle One) Mail - Fax - Will pick up

I understand that the Uniform Health Care Information Act for Montana provides the Helena Orthopaedic Clinic **ten (10) working days (Monday through Friday)** to respond to this request.

I understand that there may be a fee for this request of disclosure of the patient health record. Montana Code 50-16-540 states: Reasonable fee allowed $15 administrative fee & .50 per page.

I understand that this authorization may include disclosure of alcohol and/or drug abuse information that is protected by the provision in the Code of Federal Regulations (42CFR, part 2). This authorization may also include psychiatric and/or psychological/HIV information.

I understand that this authorization may be revoked by me at any time. The revocation is effective from the time a Revocation of Consent form is completed and given to the health care provider.

I release the above named facility from liability and claims of any nature pertaining to the disclosure of requested information contained in these medical records**. This authorization expires in one (1) year from the date of the signature unless otherwise specified.**

Signature_____
(if signed by other than patient, state relationship and authority to do so)

Date:_____

Information Released on _____ by _____ via_____(office use only)