HELENA ORTHOPAEDIC CLINIC
2442 WINNE AVE.
HELENA, MT 59601
PHONE: (406) 457-4100 FAX: (406) 457-4110

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

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

INFORMATION REQUESTED FROM:

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

_____
Mailing Address City State Zip

_____ _____
Phone Fax

Please send records to Dr. _____, Patient has an appointment on _____

The information to be release is to be used for the purpose of (Must state specific reason) (Please Circle One)

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

I request release of the following specific information for specific dates of service: Please mark all that apply

Office notes, op-reports
Emergency Room notes
Physical Therapy notes
Labs, Billing statements
MRI, Bone Scan, EMG, CT scan, etc. (Reports)
Other Physician Information
Other: _____
X-rays of: _____
Specific Dates of Service: _____

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 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_____ _____
Patient or personal representative Date
(If signed by personal representative, state relationship and authority to do so.)
Parent Spouse Guardian

Information Released on _____ by _____ via_____