AUTHORIZATION FOR RELEASE OF INFORMATION

*****IMPORTANT: In order for authorization to be valid ALL areas must be completed*****

Patient Last Name	First Name	MI	Date of Birth	Social Security Number
				___/___/___

Patient Address (PO Box/Street)	City	State	Zip	Daytime Telephone Number

I AUTHORIZE THE FACILITY BELOW TO RELEASE MY PROTECTED HEALTH INFORMATION:

□ Missoula Surgical Associates
□ Western Montana Clinic

Other:_____

_____

Outside Facility: (Complete this section ONLY if you are requesting to have records sent to one of the facilities on the left).

_____
Healthcare Provider Name

_____City/State/Zip_____
Address

_____
Telephone/Fax Number

Information to be Released

□ All medical records
□ Only medical records from _____
(Specific health care provider)
□ Only dates of service from _____to_____
□ Information from medical record for the completion of a disability form
□ Other _____

Send the Information to: _____

Address: PO Box/Street _____

City_____State_____Zip_____

Fax Information: ☐ YES ☐ NO **Fax Number**:_____(maximum of 15 pages)

Reason for Request: ___Legal ___Moving ___Review Own Records ___Insurance Claim ___Dissatisfaction ___Changing Physician
Other_____

The medical record includes all health care information, whether oral or recorded in any form or medium that identifies the patient or can readily be associated with the patient and relates to the patient's care. This includes all health care information in your/our possession, whether generated by you/us or any other source, as well as health care information associated with drug/alcohol abuse, mental or psychiatric care, abortion, and HIV status and/or diagnosis of AIDS and/or other sexually transmitted diseases including hepatitis.

The following WILL NOT be released unless you indicate your specific authorization by initialing each appropriate category:

_____Drug/Alcohol Abuse _____Aids/HIV Related Information _____Sexually Transmitted Disease _____Behavioral or Mental Health Issues

If one of the above facilities is requesting this authorization be completed, an individual has the right not to sign with the understanding that an individual's health care and the payment for health care will not be affected.

I understand that this authorization may be revoked by me at any time, provided that I do so in writing and submit it to the Medical Records Department, up to the extent that the disclosure has not already been made. I also understand that my protected health information may be re-disclosed by the recipient and no longer be protected under federal law. Authorization will expire in 6 months unless otherwise specified below.

Patient Signature (if over 18)	Date	Expiration Date
OR		
Legal Representative/Guardian	**Date**	**Relationship to Patient**

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