**AUTHORIZATION FOR RELEASE OF INFORMATION**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient (Please Print) Date of Birth Telephone Number

**INFORMATION REQUESTED FROM:**

**Benefis Health System**

Hospital – Great Falls

MRI Center – Helena

Imaging – Helena

Urgent Care – Helena

**Community Hospital of Anaconda**

**St. Peter’s Health**

Hospital

Medical Group

North Clinic

Urgent Care

**Helena Orthopedic Clinic**

**Other**

**Performance Injury Care & Sports Medicine**

**Logan Health**

(Kalispell Regional)

**Sound Health Imaging**

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

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Mailing Address City State Zip

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Phone Fax

**INFORMATION TO BE SENT TO:**

**Community Hospital of Anaconda**

**Benefis Health System**

Hospital – Great Falls

MRI Center – Helena

Imaging – Helena

Urgent Care – Helena

**St. Peter’s Health**

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**Other**

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Mailing Address City State Zip

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Phone Fax

Information Requested: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Purpose of Disclosure: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

My signature below indicates that I understand the following: Medical Records sent from another facility cannot be released. The Uniform Health Care Information Act for Montana provides this clinic **ten (10) working days (Monday through Friday)** to respond to this request. 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. This authorization may include disclosure personal information including physical, mental, drug or alcohol use, sexual assault, sexually transmitted diseases including HIV history. This authorization may be revoked by me at any time by notifying the providing organization in writing and will be considered effective upon the date of receipt of the notification. 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.**

You have the right to refuse to sign this authorization.

Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient or Representative and relationship to the patient Date