PERFORMANCE
INJURY CARE & SPORTS MEDICINE

AUTHORIZATION FOR RELEASE OF INFORMATION

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

INFORMATION REQUESTED FROM:

St. Peter's Health
Hospital
Medical Group
North Clinic
Urgent Care

☐ **Benefis Health System**
Hospital – Great Falls
MRI Center – Helena
Imaging – Helena
Urgent Care – Helena

☐ **Helena Orthopedic Clinic**
☐ **Sound Health Imaging**
☐ **Logan Health**
(Kalispell Regional)

☐ **Community Hospital of Anaconda**
☐ **Performance Injury Care & Sports Medicine**
☐ **Other**

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

Mailing Address City State Zip

Phone Fax

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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

Phillip M. Steele, MD
PO Box 4777 • Helena, MT 59604-4777
Tel: 406-422-5817 • Fax: 406-422-5928