PERFORMANCE
INJURY CARE & SPORTS MEDICINE

Phillip M. Steele, MD • Eugene 'Buzz' Walton II, MD • Abbey M. Barnhart, PA-C
3150 N. Montana Ave, Suite A • Helena, MT 59602
Tel: 406-422-5817 • Fax: 406-422-5928

AUTHORIZATION FOR RELEASE OF INFORMATION

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

INFORMATION REQUESTED FROM:

☐ St Peters Hospital
St Peters Medical Group
St Peters Urgent Care
☐ MRI Center
☐ Helena Orthopedic Clinic
☐ Helena Imaging
☐ Performance Injury Care & Sports Medicine

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

_____
Mailing Address City State Zip

_____
Phone Fax

INFORMATION TO BE SENT TO:

☐ St Peters Hospital
St Peters Medical Group
St Peters Urgent Care
☐ MRI Center
☐ Helena Orthopedic Clinic
☐ Helena Imaging
☐ Performance Injury Care & Sports Medicine

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

_____
Mailing Address City State Zip

_____
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 may refuse to sign this authorization.

Signature_____
Patient or Representative and relationship to the patient Date