

# 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 \_\_\_\_\_  
Patient Address (PO Box/Street) \_\_\_\_\_ Social Security Number \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Daytime Telephone Number \_\_\_\_\_

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

CHECK FACILITY BELOW OR COMPLETE OTHER SIDE	* AREA BELOW MUST BE COMPLETED WHEN REQUESTING RECORDS FROM AN OUTSIDE FACILITY FOR A TMI PHYSICIAN
<b>TMI Facilities</b>	<b>Outside Facility: (Complete Information Below)</b>
<input type="checkbox"/> Florence Family Practice <input type="checkbox"/> Frenchtown Family Practice <input type="checkbox"/> International Heart Institute <input type="checkbox"/> Lolo Family Practice <input type="checkbox"/> Missoula Surgical Associates <input type="checkbox"/> Montana Cancer Specialists <input type="checkbox"/> Seeley Swan Medical Center <input type="checkbox"/> Western Montana Clinic <input type="checkbox"/> Western Montana Medical Clinic Polson/Ronan	Health Care Provider Name _____ Address _____ City/State/Zip Code _____ Telephone/Fax Number _____

Information to be Released
<input type="checkbox"/> All medical records <input type="checkbox"/> Only medical records from _____ (specific health care provider) <input type="checkbox"/> Only dates of service from _____ <input type="checkbox"/> Information from medical record for the completion of a disability form <input type="checkbox"/> X-ray films _____ <input type="checkbox"/> Other _____

<b>Send the Information to:</b> _____
<b>Address:</b> PO Box/Street _____ City _____ State _____ Zip _____
<b>Fax Information:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Fax Number:</b> _____ (maximum of 15 pages)

**Reason for Request:**  Legal  Moving  Review own Records  Insurance Claim  Dissatisfaction  
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.

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 redisclosed 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) OR _____	Date _____	Expiration Date _____	Medical Records PO Box 7609 Missoula, MT 59807 406-329-7393
Legal Representative/Guardian _____	Date _____	Relationship to Patient _____	Fax: 406-329-7543 revised 07/06

Legal documents appointing representative must be attached to authorization