

# AUTHORIZATION FOR RELEASE OF INFORMATION

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

Patient Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Patient Address (P.O. Box/Street) \_\_\_\_\_ Social Security Number \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Daytime Telephone Number \_\_\_\_\_

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

### TMI Facilities

- \_\_\_\_ Florence Family Practice
- \_\_\_\_ Frenchtown Family Practice
- \_\_\_\_ International Heart Institute
- \_\_\_\_ Lolo Family Practice
- \_\_\_\_ Missoula Surgical Associates
- \_\_\_\_ Montana Cancer Specialists
- \_\_\_\_ Seeley Swan Medical Center
- \_\_\_\_ Providence Broadway Internal Medicine
- \_\_\_\_ Western Montana Clinic
- \_\_\_\_ Providence Nephrology of Montana

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

Healthcare Provider Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Telephone/Fax Number \_\_\_\_\_

### Information to be Released

- All medical records
- Only medical records from \_\_\_\_\_ (Specific healthcare provider)
- Dates of service from \_\_\_\_\_ to \_\_\_\_\_
- Information from medical record for the completion of a disability form
- X-ray films \_\_\_\_\_
- 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.

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) \_\_\_\_\_ Date \_\_\_\_\_ Expiration Date \_\_\_\_\_  
OR

Legal Representative/Guardian \_\_\_\_\_ Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Legal documents appointing representative must be attached to authorization

Medical Records  
PO Box 7609  
Missoula, MT 59807  
Fax: 406-329-7543