PATIENT AUTHORIZATION
FOR RELEASE OF MEDICAL RECORD

MONTANA ORTHOPEDICS

Patient Name:_____Phone:_____

Date of Birth:_____ Social Security Number:_____

Address:_____

I hereby authorize:_____
(Complete name of Physician, Clinic or Facility you want records sent from)

_____
(Complete Address)

_____
City State Zip

To release: (List specific description of information)

_____

Dates of service: From: _____To: _____

☐ X-ray films ☐ X-ray reports ☐ Office notes ☐ OP reports/hospital ☐ Misc.

Please allow a minimum of 10 business days for processing.

Send To: Date needed _____

_____
(Complete name of Physician, Clinic or Facility you want records sent to)

_____
(Complete Address)

_____
City State Zip

What is the purpose of this use or disclosure?_____

_____

I understand and acknowledge that this authorization extends to all or any part of the information designated above, which may include information related to treatment of physical and mental illness, and/or alcohol/drug abuse, and/or AIDS/HIV results. I expressly consent to the release of information designated above.

I understand that this authorization is valid for 1 year or until _____/_____/_____ and that I may revoke this authorization at any time by notifying the Clinic in writing, but if I do revoke it, the revocation will not have any effect on actions taken before the revocation was received.

SIGNED: _____DATE: _____
(If patient is a minor, parent/guardian please sign)

WITNESS: _____DATE: _____

☐ Mail or Deliver ☐ Patient will pick up ☐ Fax #_____

For Office Use

_____ Date sent or picked up _____ Initial _____ Charge $_____

MONTANA ORTHOPEDICS
435 SOUTH CRYSTAL, SUITE 400
BUTTE, MT 59701
(406) 496-3400
Fax (406) 496-3401

Nicholas Blavatsky, M.D.
Charles Buehler, M.D.
Nick DiGiovine, M.D.
Michael T. Gallagher, M.D.
Anthony J. Russo, M.D.

Natalie Barefield, PA-C
Jennifer Heglund, PA-C