

MISSOULA BONE & JOINT

2360 Mullan Road, Suite C

Missoula, MT 59808

Phone 406-721-4436

Fax 406-721-6053

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

Patient name _____ SS Number _____ DOB _____

Persons/organizations providing the information:

Persons/organizations receiving the information:

Name _____

Name _____

Address _____

Address _____

Fax _____

Fax _____

Specific description of information, including date(s) _____

The patient or the patient's representative must read the following statements:

1. I understand that this authorization is voluntary.
2. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
3. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.
4. I understand that I may see and copy the information described on this form if I ask for it and that I get a copy of this form after I sign it.
5. I understand that this authorization will expire 1 year from the date of signature.
6. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on my actions they took before they received the revocation.

By signing below, I acknowledge that I have read and understand the conditions of this authorization.

Signature of patient or patient's representative

Date

Printed name of patient or patient's representative

Relationship to patient

*** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION ***

You may not use this form to release information for treatment or payment except when the information to be released is psychotherapy notes or certain research information.