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:

Name _____

Address _____

_____

Fax _____

Persons/organizations receiving the information:

Name _____

Address _____

_____

Fax _____

Specific description of information, including date(s) _____

_____

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

1. Missoula Bone & Joint will not condition my treatment on whether I provide authorization for the requested use of disclosure and 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 _____

MEDICAL RECORDS FROM OTHER FACILITIES IN OUR POSSESSION NOT ORDERED BY OUR PHYSICIANS WILL NORMALLY NOT BE RELEASED

Revised 08/2012