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

TMI Facilities

- ❑ Florence Family Practice
- ❑ Frenchtown Family Practice
- ❑ International Heart Institute
- ❑ Lolo Family Practice
- ❑ Missoula Surgical Associates
- ❑ Montana Cancer Specialists
- ❑ Seeley Swan Medical Center
- ❑ Western Montana Clinic

*** AREA BELOW MUST BE COMPLETED WHEN REQUESTING RECORDS FROM AN OUTSIDE FACILITY FOR A TMI PHYSICIAN**

Outside Facility: (Complete Information Below)

_____
Health Care Provider Name

_____
Address

_____
City/State/Zip Code

_____
Telephone/Fax Number

Information to be Released

- ❑ All medical records
- ❑ Only medical records from _____ (specific health care provider)
- ❑ Only dates of service from _____
- ❑ 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
406-329-7393
Fax: 406-329-7543