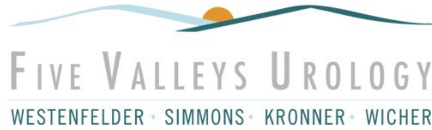

North Office - Garden City Medical Arts Building 601 W. Spruce Suite G, Missoula, Montana 59802
(406) 728-3366 (800) 370-3364 Fax (406) 329-2896
South Office – 2831 Fort Missoula Road, Physician Center II, STE 105, Missoula, MT 59804
(406) 830-3107 Fax (406) 830-3109

Authorization Form for Release of Information

Patient Name (print)**:** ____

Maiden name or any previous name (s):____

Social Security Number: _____ **-** ____ **-** ________ **Date of Birth:** ________________

I HEREBY REQUEST AND AUTHORIZE:

Name of person(s) or organization(s): ____

Address: ____

Telephone number: ______________________ Fax: ____________________________________

TO RELEASE INFORMATION FROM MY MEDICAL RECORDS TO:

Name of person(s) or organization(s):____

Address: ____

Telephone number: __________________________ Fax: ________________________________

INFORMATION TO BE RELEASED:

Complete Record	**Xrays / Ultrasound Reports**
Biopsy Results	**Laboratory / Pathology Reports**
Consultation Reports	**Other (Please specify)**

Purpose: ____

The information to be used or disclosed pursuant to this authorization form may include information relating to: (1) Acquired immunodeficiency syndrome ("AIDS") or human immunodeficiency virus ("HIV") infection; (2) treatment for drug or alcohol abuse; or (3) mental or behavioral health or psychiatric care. I may revoke this authorization at any time by notifying FVU in writing to 601 West Spruce Street, Suite G Missoula, MT 59802 of my intent to revoke this authorization. However, I also understand that such a revocation will not have any effect on any information already used or disclosed by FVU before FVU received my written notice of revocation. Unless earlier revoked, this authorization will expire on the 366th day of the signing. If neither federal nor Montana privacy law apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Montana privacy law. I may inspect and receive a copy (***Montana law establishes fees for copy charges of medical records***) of the information to be used and disclosed pursuant to this Authorization form. I understand that I am not required to sign this Authorization form in exchange for the patient receiving treatment from FVU.

______________________________________ ______________________________________

Signature of patient or Personal Representative **Printed name of patient**

______________________________________ ______________________________________

Printed name of Personal Representative *(if applicable)* **Date**