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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