2442 Winne Ave. Helena, MT 59601
Phone: 406-457-4100 Fax: 406-457-4110

Aflac Authorization For Disclosure of Medical Information

Patient Name:	Date of Birth:	Social Security #	Phone Number:
_____	_____	_____	_____

Aflac Policy Information (REQUIRED- Incomplete forms cannot be submitted to Aflac)

Date Of Injury:_____

Body Part:_____

Aflac Policy #:_____

Policy Holder:_____

☐ I am requesting my information be released to **Aflac Insurance- Helena, MT- FAX: 406-443-8087**
☐ The Information to be released is to be used for the purpose of: Insurance Claim

I REQUEST THE RELEASE OF THE FOLLOWING INFORMATION (Mark all that apply.)

☐ Office Notes
☐ Operative Reports
☐ EMG/Nerve Conduction Study Reports
☐ Billing Statements
☐ MRI/X-ray/Bone Scans/CT Reports

I would like my records sent by:	☐ Fax	☐ Mail

- I understand that the Uniform Health Care Information Act for Montana provides the Helena Orthopedic Clinic ten (10) working days (Monday through Friday) to respond to this request and there may be a fee for this request of disclosure of the patient health record. Montana Code 50-16-540 states: Reasonable fee allowed $5 administrative fee, $5.00 CD Charge & .50 per page.
- I understand that this authorization may include disclosure of alcohol and/or drug abuse information that is protected by the provision in the Code of Federal Regulations (42CFR, part 2). This authorization may also include psychiatric and/or psychological/HIV information.
- I understand that this authorization may be revoked by me at any time. The revocation is effective from the time a Revocation of Consent Form is completed and given to the health care provider.
- I release the above named facility from liability and claims of any nature pertaining to the disclosure of requested information contained in these medical records. This authorization expires in one (1) year from the date of the signature unless otherwise specified

Signature:	Date:

Information Released On: (HOC Office Use Only)	DATE:	BY:	VIA: