HELENA ORTHOPEDIC CLINIC

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

Authorization for Disclosure of Medical Information

Read Carefully- ***Failure to complete all areas will result in delays.***

Patient Name:	Date Of Birth:	Phone#:	Last 4 of SS #:

PURPOSE OF DISCLOSURE: (Select One)

- ☐ Continuity Of Care
- ☐ Workers Compensation
- ☐ Disability Claim
- ☐ Insurance Claim
- ☐ Military Records
- ☐ Attorney (Fees will apply & Pre-payment is required- Attorney must submit letter request)
- ☐ Personal Records
- ☐ Other(Specify):_____

TYPE OF DISCLOSURE : (Select one)

- ☐ I am requesting the facility named below send my information to Dr._____ @ Helena Orthopedic Clinic- Appt Date: _____
- ☐ I am requesting the Helena Orthopedic Clinic release my information to the person/facility named below

Full Name & Title of Person, Self, Hospital, Agency, Doctor, etc:

Mailing Address: Street: State: City: Zip Code:

Contact Information: Phone #: Fax #:

I AM REQUESTING THE RELEASE OF THE FOLLOWING: (Mark all that apply)

- ☐ Office Visit Notes
- ☐ Operative/Procedure Reports
- ☐ Labs/Pathology Reports
- ☐ EMG/Nerve Conduction Study Reports
- ☐ Work Status/Medical Condition Status Reports
- ☐ Billing Statements
- ☐ HIPPA- (For access to medical information/discussion no records are being requested at this time)
- ☐ MRI of:_____
- ☐ Bone Scans Of:_____
- ☐ CT Of:_____
- ☐ X-rays Of :_____
- ☐ Records Regarding the following Only:

_____

- ☐ Any/All Medical Records & Information

- 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

Method Of Delivery: (Select One)

☐ Fax	☐ Mail	☐ Email: (Personal Records Requests Only)	☐ Will Pick Up

SIGNATURE:	DATE: