Please send a copy of this form with your medical records

❑ Great Falls Clinic	❑Hospital	❑Surgery Center
1400 29th Street South	3010 15th Ave South	1509 29th St. South
Great Falls, MT 59405	Great Falls, MT 59405	Great Falls, MT 59405
(406) 771-3106	(406) 216-8070	(406) 771-3538

AUTHORIZATION FOR RELEASE OF INFORMATION

PROOF OF IDENTIFICATION IS REQUIRED TO OBTAIN RECORDS

Name of Patient:		DOB:		Phone:	
Address:		City/State:		Zip:	

I HEREBY AUTHORIZE MY PROTECTED HEALTH INFORMATION TO BE RELEASED:

TO:

Facility/Provider:	DR MICHAEL R. UPHUES, DO	Facility/Provider Fax #:	406-969-2447
Address:	724 GRAND AVENUE		
City/State/Zip:	BILLINGS, MT 59101		

FROM:

Facility/Provider:		Facility/Provider Fax #:
Address:		
City/State/Zip:		

DATES OF SERVICE _____ **to** _____ **❑ MAIL ❑ PICKUP ❑ FAX**

REASON FOR REQUEST: ❑Personal ❑Legal Review ❑Continuity of Care ❑Disability ❑OTHER _____

INFORMATION REQUESTED: *Please note – *State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained.*

*____ *(Initials)* Alcohol/Drug Abuse Treatment *____ *(Initials)* HIV/AIDS Diagnosis & Treatment *____ *(Initials)* Psychotherapy

☒All Medical Record(s) (excludes billing) or specifically those parts checked below:

❑Discharge Summary	❑History and Physical Exam	❑Operative Report
❑Consultations	❑Progress Notes	❑Radiology Results
❑Laboratory Tests	❑Pathology Report	
❑ER Notes	❑Immunizations	
❑Immunizations	❑Office Visit Notes	

❑Abstract/ Summary (Includes Discharge Summary, History & Physical Exam, Operative Report(s), Consultations and Test Results)

☒Other (please specify) _____

This authorization expires in 6 months from the date of signature unless another date, event, or condition is stated here:

YOUR SIGNATURE BELOW CONFIRMS YOU UNDERSTAND AND AGREE TO THE TERMS OUTLINED.

- I understand that this authorization may be revoked in writing at any time to the HIM Department, except for disclosures already made in response to this authorization.
- I understand that treatment, payment, enrollment or eligibility benefits may not be affected by me signing this authorization unless allowed by Federal Privacy Laws.
- I understand that if there is disclosure of this information by the recipient, it may no longer be protected by the Federal Privacy Laws.

PARENTAL REQUEST FOR CHILD'S MEDICAL RECORDS

I hereby declare under penalty of perjury, that I am the natural or adoptive parent or legal guardian of said child and there is no court order restricting or prohibiting my access to such medical records.

PARENT OR LEGAL GUARDIAN (Print Name)_____ **DATE** _____

PARENT OR LEGAL GUARIDAN (Sign Name)_____

PATIENT OR LEGAL GUARDIAN **(Print Name)** _____ DATE _____

PATIENT OR LEGAL GUARDIAN **(Sign Name)** _____ 5/22/2017