HELENA ORTHOPAEDIC CLINIC
2442 WINNE AVENUE SUITE #1
HELENA, MT 59601
PHONE: (406) 457-4100 FAX: (406) 457-4102

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Name of Patient (Please Print) _____ Date of Birth _____ Social Security Number _____

INFORMATION TO BE RELEASED TO OR PICKED UP BY:

Dr. Michael Uphues, DO Caduceus Medical Partners, LLC
Full Name and Title; Hospital, Agency, Physician, etc.

724 Grand Avenue, Billings, MT 59101
Mailing Address City State Zip

406-696-0409 406-969-2447
Phone Fax

The information to be release is to be used for the purpose of:

- ✓ Continuity of Care
- Attorney
- Insurance Claim
- Workers' Compensation Claim
- Personal Records
- Military Records
- Disability Determination
- Other: _____

I request release of the following information – please mark all that apply

- ✓ Office notes
- ✓ Operative reports
- Billing Statements
- ✓ MRI, Bone Scan, EMG, CT scan (Reports)
- Labs
- X-rays of:_____
- ✓ Medical Condition Status Report
- Work Status Report
- Access to any and all information
- ✓ Prescription Pickup
- Discussion with Physician/phone calls
- No records requested at this time

I would like my records sent by: (Please Circle One) Mail - Fax - Will pick up

I understand that the Uniform Health Care Information Act for Montana provides the Helena Orthopaedic Clinic **ten (10) working days (Monday through Friday)** to respond to this request.

I understand that there may be a fee for this request of disclosure of the patient health record. Montana Code 50-16-540 states: Reasonable fee allowed $15 administrative fee & .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_____
(if signed by other than patient, state relationship and authority to do so)

Date:_____

Information Released on _____ by _____ via_____(office use only)