

**CADUCEUS MEDICAL PARTNERS, LLC**

**Authorized for Release/Disclosure of Protected Medical Health  
Information (PHI)**

406-696-0409 Office



**Patient Name: (Please Print)**

**Date of Birth**

\_\_\_\_\_

**Name of Institution/Facility records are being requested from:**

\_\_\_\_\_

**Address:**

\_\_\_\_\_

**Fax Number:** \_\_\_\_\_ **Date requested:** \_\_\_\_\_

**Please send any and all medical records including imaging reports, labs and medication  
prescriptions to the following Physician in relation to the following condition(s) and/or dates:**

\_\_\_\_\_

**Dr. Michael Uphues, DO**

**724 Grand Avenue**

**Billings, MT 59102**

**MT State ID: 10187**

**Fax Number: 406-969-2447**

**I hereby authorize the above health care professional, medical facility, mental health facility,  
laboratory, medical records service, to release all protected health information about me**

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Authorized representative/Parent:** \_\_\_\_\_ **Relationship** \_\_\_\_\_