FAX- 406-532-0083

Authorization for Release of Medical Information

I, _____, _____/_____/_____, _____
(Name of patient) (Date of birth) (Phone number)

_____ **authorize**
(Street Address) (City) (State) (Zip)

My records to be released from: Northern Rockies Ortopaedics
(Name)
2831 Fort Missoula Road, Ste 232 Missoula MT 59804
(Street Address) (City) (State) (Zip)

My records to be sent to: Dr. Michael Uphues, DO Caduceus Medical Partners, LLC
(Name)
724 Grand Avenue, Billings, MT 59101 FAX- 406-969-2447
(Street Address) (City) (State) (Zip)

The type of information to be disclosed (check all that apply):

	Visit Date		Visit Date	Initials
_____ All Records	_____	_X_ Medication Records	_____	
_X_ Progress Notes	_____	_X_ X-ray, CT, MRI	_____	
_X_ Discharge Summary	_____	_X_ Lab Reports	_____	
_X_ History and Physical	_____	_____ Pathology Report	_____	
_X_ Consultation Report	_____	_____ Mental Health	_____	_____
_X_ Operative Report	_____	_____ Alcohol/Drug Report	_____	_____
_____ Procedure: _____		Sexually Trans Disease	_____	_____
_X_ Other: _____				
_____ HIV (AIDS) Test Results_____				

(Requires your signature here)

The purpose of the disclosure is: (check one)

_X_ Medical Care ____Payment of Claim/Benefits ____Personal Use ____Workers' Compensation
____ Legal Investigation ____Insurance Application ____ Other (please specify)_____
____I have a claim for Workers' Compensation and I specifically authorize you to engage in verbal communications with the Workers' Compensation insurer about my protected health information.

Permission to Release Records

I understand that I may revoke this authorization by written notification at any time following this date, except for the information, which may have been released prior to the revocation. Unless otherwise specified, this consent will expire six months from the signed date. This authorization will be effective for medical records generated to the date of the signature.

I understand that in accordance with State and Federal confidentiality regulations the information disclosed may include reference to or treatment of alcohol/drug abuse, emotional illness, developmental disability, or psychiatric care only if I indicated above with my initials or signature.

Acknowledgments

I understand that the information that is disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and therefore may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand I do not have to sign this authorization as a condition of receiving treatment from the Health Care Provider.

I understand that there may be a fee charged to me to cover the cost of copying and sending my records. This fee will be due and payable before my request for copies of medical records is processed.

Expiration date or condition to expire**:**____**6 MONTHS**_____

_____ _____
(Signature of person giving consent) (Date signed) (Witness) (Date signed)

The signature is of the _____ Patient _____ Parent of Minor _____ Legal Guardian
_____ Patient's Executor or Next of Kin
_____ Person authorized by Patient _____
(Specify relationship or authority to act)