Fax
406-329-5695

3600

PROVIDENCE
Health & Services

AUTHORIZATION TO USE, DISCLOSE & RELEASE PROTECTED HEALTH INFORMATION

For What States: ☐ Alaska ☐ California ☒ Montana ☐ Oregon ☐ Washington

I authorize Providence Health & Services to use and disclose a copy of the specific health information described below regarding:

Patient's Name: _____ DOB: _____

Patient/Representative Name: _____ Phone: _____

To be disclosed to: (Name of Recipient(s)): DR. MICHAEL UPHUES, DO

Recipient's Address: 724 GRAND AVENUE

City: BILLINGS State: MONTANA Zip: 59101

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

I am requesting information from the following facility(s):

Hospitals Name (List) and Phone Number	Clinics Name (List) and Phone Number

For the range of dates from: _____ to: _____

For information related to the following diagnosis or injury: _____

Information to be disclosed:

☒ History & Physical	☒ Discharge Summary
☒ Operative Report	☒ Emergency Department Report
☒ Diagnostic Reports (lab, x-ray, EKG, etc.)	☒ Progress Notes

☐ Other (specify): _____

For the purpose of: CONTINUATION OF CARE

Unless Revoked, this authorization expires in 180 days or on this Date: _____

I understand and agree that the information below will be disclosed if I place my initials in the applicable space next to the type of information.

____ HIV/AIDS testing/treatment ____ Mental Health specific visits

____ Genetic Testing ____ Drug/Alcohol specific visits

Patient Signature: _____ Date: _____

(Print form and sign by hand)

Representative Name: _____ Date: _____

Representative Signature: _____ Relation to Patient: _____

(Print form and sign by hand)