

**AUTHORIZATION FOR RELEASE OF INFORMATION**

**\*IMPORTANT – All Areas Must Be Completed**

<b>Patient Last Name</b>	<b>First Name</b>	<b>MI</b>	<b>Date of Birth</b>	
<b>Address (P.O. Box / Street)</b>		<b>City</b>	<b>State</b>	<b>Zip</b>
<b>Social Security Number</b>		<b>Daytime Phone #</b>		

**MISSOULA OB-GYN ASSOCIATES  
PHYSICIANS BUILDING #1  
2825 FORT MISSOULA ROAD, STE 217  
MISSOULA, MT 59804-7425  
PHONE 406-728-8170 FAX 406-728-9409**

**INFORMATION TO BE RELEASED:**

- **LAST 5 YEARS OF MEDICAL RECORDS**
- **PAP SMEAR RESULTS**
- **OPERATIVE REPORTS**
- **RADIOLOGY REPORTS**
- **LAB REPORTS**
- **ONLY DATES OF SERVICE** \_\_\_\_\_
- **OTHER (PLEASE SPECIFY)** \_\_\_\_\_

**PLEASE RELEASE RECORDS FROM:**

<b>Name of Doctor</b>	<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip</b>
-----------------------	----------------	-------------	--------------	------------

**PLEASE RELEASE RECORDS TO:**

<b>Name of Doctor</b>	<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip</b>
-----------------------	----------------	-------------	--------------	------------

**FAX INFORMATION: YES NO FAX NUMBER** \_\_\_\_\_

**Purpose of disclosure: 1.Transfer of Care 2.Continuation of Care 3.Medical Review  
4. Request of Individual 5.Other** \_\_\_\_\_

**PATIENT SIGNATURE (if over 18)** \_\_\_\_\_ **Date** \_\_\_\_\_ **Exp Date** \_\_\_\_\_

**Or**

**LEGAL REPRESENTATIVE/GUARDIAN** \_\_\_\_\_ **Date** \_\_\_\_\_

The medical record includes all health care information that identifies the patient and relates to the patient's care. This includes all health care information in your/our possession. We can only copy our records. We cannot forward copies of your records that we have received from any other physician. Patient health information may include drug/alcohol abuse, mental or psychiatric care, abortion, HIV status and/or diagnosis of AIDS and/or other sexually transmitted diseases including hepatitis.

If one of the above facilities is requesting this authorization be completed, an individual has the right not to sign with the understanding that an individual's health care and the payment for health care will not be affected

I understand that this authorization may be revoked by me at anytime, provided that I do so in writing and submit it to the medical records department, up to the extent that the disclosure has not already been made. I also understand that my protected health information may be redisclosed by the recipient and no longer be protected under federal law. Authorization will expire in 6 months unless otherwise specified above.

