MEDICAL RECORDS RELEASE FORM

Patient Name ________________________________ Patient DOB ___________________
Patient alias(es), other names, maiden names __________________________________
Patient phone number _______________________
Person requesting records and relationship to patient _____________________________

Purpose of request (please mark any boxes that apply):
[] continuing medical care [] legal purposes [] insurance [] military
[] personal use [] school [] social security / disability [] other

I, the undersigned, authorize the release of, or request access to the protected health information specified below from the medical record(s) of the above named patient.

Specific records requested
[] Clinic notes [] immunization reports [] laboratory records
[] pathology reports [] hospital admission & discharge notes
[] Other (please specify)________________________________
Specific dates of records requested, if any: from _______________ to _________________

Please place your initial beside each option below to authorize the release of sensitive information pertaining to:
Drugs or alcohol _______ Genetic testing ________ Mental health / psychiatric history ______
HIV / AIDS / sexually transmitted disease / other infectious disease ______
Or initial to indicate these options are not applicable / do not apply ______

Release records (circle one) TO / FROM:
Facility / Physician / Provider / Organization ____
Street Address ____
City ______________________ State __________ Zip __________
Phone ___________________ Fax ____________

Release records (circle one) TO / FROM:
Beargrass Family Medicine, PLLC
445 W Alder St, Missoula, MT 59802-4121 | Phone 406-510-1800 | Fax 1-833-944-2315

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

_______________________________________ _____________________
Signature of patient or authorized representative Date

_________________________________ ____
Printed name of authorized representative Witness signature (only needed for release of mental health records)