PARTNERSHIP HEALTH CENTER (PHC) **(406) 258-4789**
323 W. Alder, Missoula, MT 59802 **FAX (406) 258-4732**

AUTHORIZATION FOR RELEASE OF INFORMATION

I WANT PHC TO *GET* MY RECORDS *FROM*

THE FOLLOWING PROVIDER AND THEREFORE I AUTHORIZE THEM TO RELEASE RECORDS TO PHC:

Provider's Name

Medical Facility Name or Address

City State Zip

Telephone number Fax Number

I WANT PHC TO *SEND* MY RECORDS *TO*

THE FOLLOWING PROVIDER AND I AUTHORIZE PHC TO RELEASE RECORDS TO:

Dr. Michael Uphues, Do

Provider's Name

3600 Marathon Dr

Billings Mt 59102

City State Zip

406-696-0409 406-969-2447

Telephone number Fax Number

OR _____ **I AM REQUESTING A *COPY* OF MY RECORDS. THE FEE FOR COPYING RECORDS IS: $15.00 PLUS .50 CENTS PER PAGE WHICH MUST BE PAID BEFORE RECORDS WILL BE COPIED.**

Patient's Last Name First MI Date of Birth

Any other name known by Social Security Number

Patient's Mailing Address

City State Zip Daytime telephone number

INFORMATION TO BE RELEASED:

X Progress Notes
X Lab Reports
X X-ray Reports
_____ Bills for Services
_____ Payments Received
_____ Other
X Specific info relating to:

SPECIFY DATE(S) OF VISIT/TREATMENT:

PLEASE SPECIFY THE REASON FOR YOUR REQUEST:

_____ Medical Care
_____ Insurance
_____ Legal
_____ Patient Request
_____ Disability
X Other:

I understand that my records may contain information regarding the diagnosis or treatment of AIDS (acquired immunodeficiency syndrome) or infection with HIV (human immunodeficiency virus), substance abuse (drugs and/or alcohol), psychiatric/psychological or mental health care, or sexually transmitted diseases. I give my specific authorization for these records to be released. I understand that only records generated by Partnership Health Center will be released.

I understand that this authorization may be revoked by me at any time, provided that I do so in writing, up to the extent that the disclosure has not already been made. The revocation is effective from the time it is communicated to the health care provider. **If not revoked, this authorization expires in six (6) months from the date of signature unless otherwise specified. (MCA 50-16-527)**

It is my intent that information furnished is prohibited for any purpose other than that stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above.

Patient's Signature Date

Patient's Authorized Representative (If patient unable to sign) Relationship Date

Signature of Witness (only required for Mental Health Record requests) Date