Patient Name: _____ Medical Record #_____ Date of Birth _____

Address:_____
_____ Telephone_____
For the period(s) of health care from (date) _____ to (date) _____

1. I hereby authorize Shriners Hospitals for Children®, _____ to disclose to:
   Name: DR MICHAEL R. UPHUES, DO
   _____
   Street Address: 3600 MARATHON DRIVE
   City, State & Zip Code: Billings, MT 59102

2. Information to be disclosed:

☒ Discharge summary	☒ Progress notes	☒ Operative reports
☐ History & physical examination	☐ Laboratory tests	☐ Consultation reports
☒ X-ray reports	☒ X-ray films/images	☐ Photographs/slides
☐ Billing Statements	☐ Other _____	

3. Reason for disclosure:_____

4. Separate signature required for release of information related to items below. Initial each line if required.
   ___ Acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV)
   ___ Behavioral health services/psychiatric care/psychotherapy records
   ___ Alcohol and substance abuse diagnosis and treatment records
   ___ Pregnancy, contraceptives, and sexually transmitted diseases
   ___ Genetics testing
   Signature for release of information in Item 4:_____

5. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. **Unless otherwise revoked, this authorization will expire one year (12 months) from the original date for release of information to family members; six (6) months from the original date for all other releases.**

6. I have had the opportunity to ask questions regarding this Authorization and these questions have been answered fully.

7. I hereby release and agree to indemnify and hold harmless Shriners Hospitals for Children, it successors and assigns, and its agents and employees, from and against any claim or cause of action based on the release of requested health records and/or health information I previously authorized.

8. The recipient of this information might disclose it to other people. Shriners Hospitals for Children has no way to prevent this re-disclosure and cannot be held liable for such re-disclosures.

☐ I understand that I do not have to and have chosen not to sign this Authorization. My failure or refusal to sign will not affect my child's or my treatment or ability to receive treatment at Shriners Hospitals for Children.

_____ AM/PM
Signature of patient (14 years or older) Date Time

_____ AM/PM
Signature of the Parent/Legal Guardian Date Time

_____
Print Name Relationship to Patient

_____ AM/PM
Signature of the Witness Date Time

_____
Name (Print)

_____ AM/PM
Signature of the Parent/Legal Guardian Date Time

_____
Print Name Relationship to Patient

_____ AM/PM
Signature of the Witness Date Time

_____
Name (Print)

Authorization for Disclosure of Health Information
Shriners Hospitals for Children®

Patient Information Label

UDA001A