



Fax - 406-249-2415

AUTHORIZATION TO USE, DISCLOSE & RELEASE PROTECTED HEALTH INFORMATION

For what States: Alaska Montana Washington

I authorize PH&S or Swedish to use and disclose a copy of the specific health information described below regarding:

Patient's Name: [] DOB: []

Patient's Address: [] Phone: []

To be disclosed to: (Name of Recipient(s)): Dr. Michael Uphues, DO

Recipient's Address: 3600 Marathon Drive

City: Billings State: Montana Zip: 59102

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

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

Table with 2 columns: Hospitals Name (List) & Phone Number, Clinics Name (List) & Phone Number

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: []

Unless revoked, this authorization expires in 180 days or on this Date: []

Terms: This authorization, unless expressly limited by me in writing will extend to all aspects of testing and/or treatment of sexually transmitted diseases, AIDS, HIV Infection, alcohol and/or drug abuse, mental health conditions or other sensitive information.

Patient Signature: [] Date: []

Patient Representative Name: [] Date: []

Patient Representative Signature: [] Relation to Patient: []