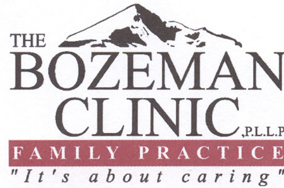
Gabor Benda, MD
David McLaughlin, MD
Leonard Ramsey, MD
Heather Wheeler, MD
Steve Roberts, DO
Christine Mitchell, MD



Bozeman Clinic
931 HIGHLAND BLVD STE 3360
Bozeman, MT 59715
phone: (406)587-4242
****DO NOT FAX RECORDS****

REQUEST FOR RELEASE OF MEDICAL RECORDS

Please send records from last 3 years unless otherwise specified

These records are to be released for the purpose of:_____________________________
Release records from:______________________Send to:_________________________
Address__________________________________Address:_________________________
__________________________________ _________________________

I authorize the following information to be disclosed covering the period of health care:
From (date)_____________________________To (date)___________________________

____All Medical Records ____Progress Notes
____Lab Tests ____X-ray Reports
____Immunization Records ____X-ray Films of________________________
____Other (specify)____

I DO NOT WISH to release information relating to (check if applicable):
____Acquired immunodeficiency (AIDS) or human immunodeficiency virus (HIV)
____Behavioral health services/psychiatric care
____Treatment for alcohol or substance abuse
____Does not apply to my medical history ____(Initial)

Initial if you understand:

1. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance of this authorization. Unless otherwise revoked, this authorization will expire in six months. ________(Initial)
2. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. _____(Initial)
3. Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules. ____(Initial)

Other Rights:

1. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign the form to assure treatment. However, if this authorization is needed for participation in a research study, enrollment in the research may be denied.
2. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

______________________ ______________________ ______________________
Name (print) Date of Birth Social security number

______________________ ______________________ ______________________
Signature Date Witness
(parent or legal guardian please sign for minors)

Office use only: Chart #: ____________________ DateMailed:_____________Initial__________________

PHOTO ID REQUIRED TO OBTAIN MEDICAL RECORDS DUE TO FEDERAL REGULATIONS

*****PLEASE MAIL RECORDS. DO NOT FAX.*****