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THE BOZEMAN CLINIC P.L.L.P.
FAMILY PRACTICE
"It's about caring"

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.*****