Release of Records

I hereby authorize ____

(Name of Provider and Health Care center where records are located, please list their fax and phone number)

To release the records of:

Name:____ DOB: _______________________

To: Frenchtown Family Medical and Wellness | PO Box 535 Frenchtown, MT 59834

Phone: (406) 541-4700 | Fax: (406) 541-4701

If my records are with CMC or a Providence location I authorize my medical records to be accessed electronically.

Reason: Sharing with other health care providers as needed

The type of information to be used or disclosed is as follows (check appropriate box)

_____ Discharge Summary

_____ Imaging

_____ Immunization Records

_____ History and Physical

_____ EKG

_____ Lab Results

_____ Entire Record

_____ Other (please specify) ____

I understand that the record release may contain the following information which is protected by state and federal law and I authorize you to release this information (initial all that apply)

_____ Mental Health Treatment

_____ Drug and Alcohol Abuse

_____ AIDS / HIV related information

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke authorization, I must do so in writing and present my written revocation to the clinic. I understand that the revocation will not apply to information that has already been released. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal or state privacy laws or regulations.I understand that the use and disclosure of the information identified above is voluntary. I need not sign this form to ensure health treatment. I acknowledge that I might be charged a reasonable, cost based fee for making copies. I acknowledge that third party payers and other parties requesting health information on behalf of myself will be charged as state law allows.

Signature of patient or legal guardian: ________________________________ Date: __________

Parent/legal guardian printed name: ____

Relationship to Patient:____