Release of Information

I, _____
(Print Patients Name) (Date of Birth)

Hereby Authorize: _____
(Name of Hospital/Facility)

_____
(City and State) (Phone/Fax)

To release the records to:

Frenchtown Family Medical and Wellness | PO Box 535 Frenchtown, MT 59834
Phone: (406)541-4700 | Fax: (406)541-4701

Reason: Sharing with other health care providers as needed

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

☐Entire Record ☐ Labs ☐Imaging ☐History and Physical ☐ EKG
☐Immunization Records ☐ Discharge

Date Range:
From: _____ To: _____

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 relation 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.

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

Signature of patient or legal guardian: _____ Date: _____

Parent/legal guardian printed name: _____

Relationship to Patient: _____This authorization expires: _____