



# MISSOULA BONE & JOINT

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## AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

Patient name \_\_\_\_\_ SS Number \_\_\_\_\_ DOB \_\_\_\_\_

**Persons/organizations providing the information:**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Fax \_\_\_\_\_  
Email \_\_\_\_\_

**Persons/organizations receiving the information:**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Fax \_\_\_\_\_  
Email \_\_\_\_\_

**Medical Records being requested, including date(s) and body part(s):**

Office Notes \_\_\_\_\_  Imaging Reports (MRI or X-ray) \_\_\_\_\_  
 OP Reports, Date(s) \_\_\_\_\_  All Records \_\_\_\_\_  
 Other, please specify \_\_\_\_\_

**Delivery Method:**  Mail  Fax  Pick Up  Email: \_\_\_\_\_

**Imaging being Requested, Including date(s) and body part(s):**

MRI Images \_\_\_\_\_  X-ray Images \_\_\_\_\_  
 All Imaging \_\_\_\_\_  Other, please specify \_\_\_\_\_

**Delivery Method:**  CD  USB  Pick Up  Mail  Email (X-ray only): \_\_\_\_\_

**The patient or the patient’s representative must read the following statements:**

1. Missoula Bone & Joint will not condition my treatment on whether I provide authorization for the requested use of disclosure and I understand that this authorization is voluntary.
2. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
3. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.
4. I understand that I may see and copy the information described on this form if I ask for it and that I get a copy of this form after I sign it.
5. I understand that this authorization will expire 1 year from the date of signature.
6. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won’t have any effect on my actions they took before they received the revocation.

**By signing below, I acknowledge that I have read and understand the conditions of this authorization.**

\_\_\_\_\_  
**Signature of patient or patient’s representative** **Date**

Printed name of patient or patient’s representative \_\_\_\_\_

Relationships to patient \_\_\_\_\_