Frontier Family Practice
201- 1st Ave North Fairfield, MT 59436
Phone (406)467-3447 Fax (406)467-3407

Authorization for Release of Information

Full Name of Patient:_____DOB_____

Address_____Phone_____

Date Needed:_____

- □ **To Mail**
- □ **To Pick Up**
- □ **To Fax**

Name and address of Physician, Facility, or third Party records or information to be released:

From:_____
_____
_____
_____

To: Frontier Family Practice
201 1st Ave N, Box 37
Fairfield, MT 59436
406-467-3447 Fax 406-467-3407

Information Requested:
____Progress Notes
____Hospital
____X-ray
____Other:_____

All health care information, whether oral or recorded in any form or medium, that identifies the patient or can readily be associated with the patient and release to the patient's care, this will include all health care information in your possession, whether generated by M.D. or any other source, also included will be health care information associated with drug or alcohol use, mental or psychiatric care and HIV status or diagnosis of AIDS, or other sexually transmitted diseases.

This authorization shall be valid for six (6) months from the date recorded on the authorization unless otherwise revoked or the shorter time period stated here_____. An updated signature form is needed every six (6) months. This release is subject to revocation at any time. If revoked, the release terminates in accordance with Montana State Statute 50-16-527. The undersigned understands that this authorization may be revoked at any time, upon written notification from Frontier Family Practice, except to the extent that Frontier Family Practice, who is to make the disclosure, has already taken action in reliance.

Patient Signature:_____Date:_____

Guardian Signature:_____Date:_____
(If patient under age 18)

Relation to Patient_____