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(406) 728-8544
please phone if faxing records

Authorization form to release/request health records

Patient Name: _____

Date of birth: _____

Patient Address: _____

Daytime Telephone Number: _____

Information to be released/requested:

- Prenatal records
- Health records
- Lab work
- X-rays
- Other: _____

- I authorize Dr. Dunne to request my health information from:

Purpose of Disclosure:

- Comprehensive Integrative Care
- Other: _____

The patient has the right not to sign the authorization with the understanding that the individual's health care and the payment for health care will not be affected.

I understand that this authorization may be revoked by me at any time, provided that I do so in writing and submit to that above address.

I also understand that my protected health information may be redisclosed by the recipient and would no longer be protected under federal law.

Patient Authorization expires 1 year from date of signed release.

Patient Signature

Date

Legal Guardian

Date

Relationship to Patient