



AUTHORIZATION TO RELEASE PROTECTED INFORMATION

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300 North Willson Avenue, Ste 1003
 Bozeman, Mt 59715
 406-587-1245

422 South Main Street
 Livingston, Mt 59047
 406-587-1245

205 West Main Street
 Belgrade, Mt 59714
 406-587-1245

medicaleyebozeman.com

Staff Use Only	<input type="checkbox"/> Received	Date: _____	Initials: _____
	<input type="checkbox"/> Processed/Faxed/Mailed	Date: _____	Initials: _____
			<input type="checkbox"/> SCAN ONLY

1. Patient Information:

Patient Name (First, Middle, Last): _____	Date of Birth (mm-dd-yyyy): _____	Daytime Phone: _____
Patient Address (Street, City, State, Zip): _____		

2. Release Purpose:

Check appropriate box or write in other purpose.

Transfer of Care
 Referral
 Personal Records
 Legal
 Insurance

Other, specify: _____

3. Release Information FROM:

Check one box and complete if applicable.

Medical Eye Specialists

Other, specify organization, department, or individual (complete each line below)

Street: _____

City: _____

State: _____ Zip: _____

Phone: _____

Fax: _____

4. Release/Send Information TO:

Check one box and complete if applicable.

Medical Eye Specialists
 300 North Willson Avenue, Ste. 1003
 Bozeman, MT 59715-3551
 Fax: (406) 587-1092

Other, specify organization, department, or individual (complete each line below)

Street: _____

City: _____

State: _____ Zip: _____

Phone: _____

Fax: _____

This authorization will expire in 1 year from date of signature unless another date is specified: _____

- By checking this box I allow the ongoing exchange of information between the above parties until this authorization expires or is revoked.
- By checking this box I also authorize the release for future visits after the date of my signature until this authorization expires or is revoked.



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5. Records to Be Released:

Timeframe to Be Released	
Date(s): _____ (mm-dd-yyyy)	or Year(s): _____ (mm-dd-yyyy)
Document/Note(s) (check all that apply)	
<input type="checkbox"/> Medical Records	<input type="checkbox"/> Radiology Reports
<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Photos & Visual Fields
<input type="checkbox"/> Operative Reports	<input type="checkbox"/> H&P Reports
<input type="checkbox"/> Other: _____	

6. Delivery Options:

<input type="checkbox"/> Mail	<input type="checkbox"/> Pick-Up	<input type="checkbox"/> Fax (Healthcare Facilities Only)
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7. Signature and Date: The patient or legal representative must sign and date this authorization.

I hereby consent to the release of any and all records containing Alcohol/Drug Abuse/HIV/Psychiatric diagnoses under the same consideration as above. I understand that such information cannot be released without my specific consent, except under a Court Order. It is my intent that information released is prohibited for any other purpose than that which is stated above.	
Note: A patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law. Specific situation(s) may require minor's authorization.	
Signature: (required) ▶	Date: (required) (mm-dd-yyyy)
Printed Name of Person signing: (if not patient) (First, Middle, Last)	
Relationship if Not Patient: (legal documentation of the right of access by the signing individual may be required)	
<input type="checkbox"/> Parent <input type="checkbox"/> Stepparent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Foster parent <input type="checkbox"/> Power of attorney/agent <input type="checkbox"/> Other: _____	