Partnership Health Center (PHC)
Medical Records Department
323 W Alder St, Missoula, MT 59802
PHONE: (406) 258-4789 option 5 / FAX: (406) 258-4732

Patient Name: _____ Date of Birth: _____

Other Name(s)Used / Maiden Name:_____ Phone Number: _____

REQUEST COPY OF MY PRIVATE HEALTH INFORMATION FROM:

DOCTOR/ CLINIC/OTHER: _____ Phone: _____
Address: _____ Fax: _____
City: _____ State: _____ Zip: _____

I need this for: (Please check one) ☐ Myself ☐ Another doctor ☐ Continuity of care ☐ Other

I need the following records to be sent to PHC: (please **initial** those that apply)

_____ Clinic Notes/Records _____ Pathology Records _____ Results of (X-Rays, MRIs, CT Scans, etc.)
_____ Immunization (shot) Records _____ Specific Date(s): _____ to _____
_____ Lab Records _____ Specific Information only: _____

I understand that the records sent may contain records which are protected by state and/or federal law and I do not need to agree to send them. If I still want you to send those records I will **initial** them below:

_____ ***Mental Health Treatment** _____ ***Drug and Alcohol Treatment** _____ *AIDS/HIV related information

RELEASE MY PROTECTED HEALTH INFORMATION TO: (Two Options Below - Please check **ONLY** one)

1. _____ I want a copy of records for myself. (Initial the records you are requesting below)

2. _____ I want you to **Release** my records to the following: (Initial the records you are releasing below)

Doctor/Clinic/Other: _____ Phone: _____ Fax: _____
Address: _____ City: _____ State: _____ Zip: _____

Initial the records you are requesting.

_____ Clinic Notes _____ Shot Records _____ My visit schedule _____ Pathology Records
_____ Billing Information _____ Lab Records _____ Specific Date(s): _____ to _____
_____ Specific Information only: _____

By signing this form, I understand that:

a. Only records created by Partnership Health Center will be sent.
b. I have the right to change my mind at any time. If I cancel this release it must be done in writing. I understand some records may have already been sent before I cancel.
c. I choose to sign this form. I can also refuse to sign this form. I need not sign this form to receive care, payment for services, or get insurance help.

I may see a copy of this form as per (law 45 CRF 164.524). I understand that once my notes are sent to someone else, the information may not be protected by state or federal confidentiality rules. If I have questions about who can see my health information, I can contact Partnership Health Center's Medical Records staff.

Patient/Authorized Representative *Signature: _____Date: _____

* If signed by a patient's authorized representative, supporting legal documentation must accompany this authorization form.

Witness signature (only required for Mental Health Records): _____ **EXPIRATION DATE**: _____

Revised: 3/6/15, 3/19/15, 11/17/15,2/3/16 , 08/25/16, 2/26/18, 07/19/2018

Unless otherwise revoked, this authorization will expire six months after it is signed