

GREAT FALLS ORTHOPEDIC ASSOCIATES
1401 25TH STREET SOUTH ~ GREAT FALLS, MT 59405
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AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

*****NOTICE***** There is a charge for medical records, unless we are sending them directly to another physician/provider. Also, if this form is not filled out completely the request **WILL NOT BE PROCESSED**. Thank You.

~Please allow 7 – 10 business days for process of medical records~

I hereby authorize you to release the following information from the medical record of:

Patient Name: _____
Date of Birth: _____
Address: _____

Phone: _____

The information to be released **FROM**:

Name: _____
Address: _____
City, State, Zip: _____
Phone: _____

The information is to be released **TO**:

Name: _____
Address: _____
City, State, Zip: _____
Phone: _____

Information requested:

- () All Medical Records
- () Records Related to Specific Problem of: _____
- () X-RAYS (GFOA, The Heights Imaging Center – MRI)
Please Mark One: () CD () Reports
- () Other: _____

Signature of Patient or Legal Representative

Date

Relationship to Patient

Expiration Date of Authorization

This authorization is effective through ____ / ____ / ____ (one year)
Unless terminated by the patient or the patient's personal representative.