



Joshua Bowler, MD
Heather Hansen, MD
Steven Klepps, MD
Thomas Owen, MD

Brian Drake, DO
Jessica Hart, MD
Kyle Lybrand, MD
Ben Phipps, MD
Mario Quesada, MD

James Elliott, MD
Bryon Hobby, MD
Jacob Mushaben, DO
Zachary Scheer, MD
Michael Yorgason, MD

Michael Groover, DO
Christopher Hyer, DPM
J. Eric Neal, MD
Thomas Spears, DO

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone #: _____

I authorize Ortho Montana and its employees, agents or associated healthcare practitioners to use or disclose the patient's protected health information as described below.

1. Relevant Time Period: Ortho Montana may use or disclose information relating to healthcare provided during the following time period:

- ☐ Anytime
☐ Healthcare provided between (date) _____ and (date) _____.

2. Types of Information: Ortho Montana may use or disclose the following type(s) of information:

- ☐ Any information concerning the Patient's healthcare or payment during the relevant time-period
☐ Medical records concerning the Patient's healthcare during the relevant time-period, including:
☐ Records from the Patient's chart (e.g., history, examination, progress notes, lab results, diagnostic test results, operative reports, discharge summaries, photographs, etc.)
☐ Diagnostic images, films or other recordings (e.g., x-rays, MRI scans, CT scans, etc.) CD fee \$15 _____
☐ Billing and payment records for healthcare rendered during the relevant time period.
☐ Other: _____

3. Persons to Whom Disclosure Allowed: Ortho Montana may disclose and verbally discuss the information to the following entity(ies):

Name or Company: _____

Address: _____

Phone number: _____ Fax number _____

4. Purpose: Ortho Montana may use or disclose the information for the following purpose(s):

- ☐ The disclosure is made at the Patient's request.
☐ For a potential or pending legal proceeding
☐ Continuation of Care
☐ No records sent at this time/ Verbal use only. Please keep on file.
☐ Other: _____

5. Method of Delivery

☐ USPS Mail ☐ Pick up in Office ☐ Fax: _____ ☐ Email: _____

I understand that I have the right to revoke this authorization at any time except to the extent that Ortho Montana has taken action in reliance on this authorization. To revoke this authorization, I must submit a written revocation to:

Ortho Montana 2900 12th Ave North Suite 140W Billings, MT 59101

I understand that Ortho Montana may not condition the Patient's healthcare on this authorization unless (1) the purpose for Ortho Montana's evaluation and treatment is to obtain and disclose information to entities consistent with this authorization, or (2) the Patient is involved in research-related treatment and the use or disclosure is for such research.

I understand that information disclosed by Ortho Montana pursuant to this authorization may be re-disclosed by the entity who receives this information and may no longer be protected by privacy regulations.

I understand that Ortho Montana may receive reimbursement from the requestor to cover the cost of copying my medical records.

This authorization will expire on the following date or event: _____. If no specific date or event is stated, this authorization will expire two (2) year from the date of this authorization.

Signature Date Printed Name

Authority or relationship to the Patient

****For Office Use Only****

_____ Initials (received by) _____ Date Received _____ Initials (released by) _____ Date Released _____ Scan Only