Sage Medical Clinic
Phone 406-443-7733 Fax 406-443-8292

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

PATIENT INFORMATION	PATIENT: _____ DATE OF BIRTH: _____ Address: _____ Phone #:_____ City: _____ State: _____ Zip:_____
Clinic/Hospital/Health Care Provider (**Who** has the information you want released?) Please list the specific Hospital and/or clinic	Provider: ***Sage Medical Clinic*** Address: ***820 North Montana Avenue*** City: ***Helena*** State: ***MT*** Zip: ***59601*** Phone #***406-443-7733*** Fax #:***406-443-8292***
Receiving Party (**Where** do you want the information sent?	NAME: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone #:_____ Fax #:_____
Information to be Released (**What** do you want sent or released? Check the appropriate box.)	_____ Any and all records (include ALL types of record listed below.) Only records types checked below: ____ Discharge summary/note ____ Radiology reports ____ Medication Reports ____ History & physical exam ____ Immunization/allergy record ____ Operative Reports ____ Laboratory reports ____ Consultations ____ Progress/clinic notes ____ Pathology reports ____ Other records (please specify types) _____
	Items in this box will be released unless checked: ____ Physician's Psychiatric Diagnoses ____ Alcohol and Drug Info/Treatment ____ AIDS/HIV/STD Testing and Results
Purpose of Release (**Why** is it needed?)	___ Continuing Care ___ Transfer of care ___ Other ___ Personal Use or review

- This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____
- This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation.
- Sage Medical Clinic will not restrict my treatment if I choose not to sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- Sage Medical Clinic cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Sage Medical Clinic from any and all liability resulting from a re-disclosure by the recipient.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

_____ _____ _____

Patient or Parent/Legal Guardian Signature Date Relationship