

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

Dr. Diane Eodice, Dr. Sheri Howell, Dr. Richard Sargent, Dr Kurt Werner, Erin Kuntzweiler APRN, Somer Mazzucola DNP

**AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION**

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