Alpine Orthopedics and Sports Medicine
536 Cottonwood Road, Suite 100
Bozeman, MT 59718
Phone: (406) 586-8029
Fax: (406) 586-8009

Authorization to Use or Disclose Protected Health Information (PHI)

Written authorization from the patient or legal reprsentative is required. All Items must be completed to be considered valid. Please print clearly.

Please note it may take up to 30 days for your records to be processed.

I hereby authorize, Alpine Orthopedics & Sports Medicine to use/disclose my individually identifiable health information as described below (which my include information concerning treatment for drug/alcohol abuse, mental health, HIV status, or genetic testing records, if applicable. - If I do NOT want this information sent, I must indicate below.) I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or health care provider; the released information may no longer be protected by the federal and state privacy regulations.

1. Patient Information		
Name:	Birthdate:	
Address:		Phone Number:
City:	State:	Zip:

2. Authorization to Release (FROM): I authorize the release of my PHI from the entity identified below		
Name of Facility: Alpine Orthopedics and Sports Medicine		Phone Number: 406-586-8029
Address: 536 Cottonwood Road, Ste 100		Fax Number: 406-586-8009
City: Bozeman	State: MT	Zip: 59718

3. Information to be disclosed (please check). Related dates:
☐ Office Notes:
☐ MRI:
☐ Images (i.e. MRI/X-Ray disc):
☐ Other (please describe):

4. Authorized to Receive (TO): I authorize the entity identified below to receive my PHI		
Name of Facility:		Phone Number:
Address:		Fax Number:
City:	State:	Zip:

5. The PHI will be disclosed as identified below (please check). Note we cannot email PHI. Any requests for images will need to be mailed.
☐ Emailed:
☐ Faxed:
☐ Mailed:

6. Purpose for disclosure (pleae check)
☐ Personal Copy
☐ Legal
☐ Disability
☐ Insurance
☐ Other

7. In addition I authorize Alpine Orthopedics & Sports Medicine to EXCLUDE information relating to: (Please check)
☐ Acquired Immunodeficiency Virus (HIV)
☐ Psychiatric care
☐ Treatment for alcohol and/or substance abuse
☐ Genetic testing

I understand that this authorization is valid for 12 months after the date signed, unless I otherwise specify. I further understand that I may revoke this authorization at any time by notifying Alpine Orthopedics & Sports Medicine in writing. This written revocation must be signed and dated with a date that is later than the date on this aurthorization.

If original X-Rays taken prior to 9/1/11 are requested, I understand that by signing this release I am acknowledging that I am taking full responsibility for the care of these X-Rays and if they are damaged or lost they cannot be replaced. Alpine Orthopedics & Sports Medicine is not responsible if these films are lost of damaged. Original films should be returned as soon as possible.

8. Signature	
Printed name of patient:	Date:
Signature of patient or personal representative:	Legal authority of personal representative: