Bridger Orthopedic
C/o Medical Records-Release of Information
1450 Ellis Street, Suite 201
Bozeman, MT 59715-8813
Phone: (406) 587-0122
Fax: (844) 656-2480

AUTHORIZATION FOR USES & DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

Instructions: Bridger Orthopedic requires a completed and signed authorization to release health information to anyone, including the patient. The **patient or Legal representative** must complete the authorization form to disclose private health care information. Mail or fax your completed, signed request to the Medical Records-Release of Information. The address and fax are listed above. You may drop off the form at any of our locations during business hours.

- The original medical record is property of Bridger Orthopedic
- Medical Records or Imaging sent from another facility cannot be released
- There is a minimum 10 day waiting period
- There may be a fee for this service. Montana Code Annotated 50-16-540 allows a reasonable fee for providing health care information may not exceed 50 cents for each page for a paper copy or photocopy. A reasonable fee may include an administrative fee that may not exceed $15 for searching and handling recorded health care information.
- I acknowledge that the released information may contain alcohol, drug abuse, HIV, and mental health information.
- I understand that I may revoke this authorization at any time by notifying Bridger Orthopedic in writing.
- This authorization will expire twelve months after the date of signature.

Patient name: (Last, First, Other/Alias)	DOB:	Phone #:
Address:	City:	State/Zip:

Purpose of Disclosure:
_____ Transfer of Care _____ Referral _____ Personal Records _____ Legal _____ Insurance

_____ Other: _____

Information to be Released:
_____ Specific Date(s) From: _____ To: _____ _____ All past, present encounters/visits

_____ Radiology/Advanced Imaging _____
____ Entire Record _____ Images _____ Report only

_____ Other _____

Delivery Options:

_____ Mail _____ Pick-Up _____ Fax (Healthcare Facilities ONLY) _____ Athena Patient Portal

I have read the above and authorize the disclosure of the protected health information as stated

Signature of Patient/Patient Representative	Date:
Print Name of Patient/Patient Representative	*Relationship or scope of your legal authority to act on the patient's behalf:

*Supporting documentation may be required. 4/2021