Bridger Orthopedic
C/o Medical Records-Release of Information
3400 Laramie Drive
Bozeman, MT 59718
Phone (406) 577-7689 / Fax: (844) 656-2480

AUTHORIZATION FOR ACCESS/USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize the access, use, or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the release information may no longer be protected by federal privacy regulations **and further charges may apply.** The original medical record is property of Bridger Orthopedic.

Medical records or imaging sent or taken from another facility cannot be released.

Patient name: (Last, First, Other/Alias)	DOB:	Phone #:

Please allow 10 business days for your request to be processed.

Medical record copy fees are determined by both the nature/purpose of your request and the format/method of delivery.

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.

- Specific Date(s): _________ to _____________

Please check all that apply or describe the information specifically

□ Office visit notes □ MRI reports □ CT report □ Dexa report □ Lab Reports □ Pathology Reports
□ Operative Reports □ Physical Therapy □ CD of images ($5.00)- ***Bridger Orthopedic images only***

□ Other: ____ **Total Collected: _______________________**

I request my protected health information (PHI) to be released to the following person or organization.
□ Self (Patient) □ Third party

Facility /location: ____ Physician: ______________________________
Address: ____
Fax # if known: ______________________________(Bridger Orthopedic will only fax records to Healthcare Facilities)

Delivery Options:
□ Mail Facility □ Fax Facility (Healthcare Facilities Only □ Mail Patient
□ Patient will pick up records at ***Bridger West (3400 Laramie Drive)***
****Please note if you do not pick up your records within 2 weeks your records will be mailed to the address we have on file.****

I have read the above and authorize the disclosure of the protected health information as stated.
This authorization will expire 12 months after the date of signature

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 3.22.23