Providence Surgery Center
902 North Orange Street
Missoula, Montana 59802
Phone 406 327-3300 * Fax 406 327-3302

✶ AUTHORIZATION FOR RELEASE OF INFORMATION ✶

Patient Number _____
(For Office Use Only)

Social Security Number _____ Telephone Number _____

I, _____, born on _____/_____/_____, hereby authorize:
Patient Last Name First Name Mo. Day Year

_____ Providence Surgery Center
_____ Other Provider (Please specify and include address and fax number)

_____

_____

to release medical information :

_____ Providence Surgery Center
_____ Other Provider (Please specify and include address and fax number)

_____

_____

the following information regarding my care and or treatment on the following dates:

_____

Purpose of Disclosure: _____

I understand and acknowledge that this authorization extends to all or any part of the information designated above, which may include treatment for physical and mental illness and/or alcohol, drug abuse and/or AIDS, and/or HIV results. I expressly consent to the release of information designated above. This consent is valid for 60 days, unless revoked by my written notice, provided written notice is received prior to the release of the above designated information.

X _____ _____
Signature of Patient or Person Authorized to Consent Date

_____ _____
Relation ship to above, if not Patient Witness required if patient unable to sign

If questions, please call Providence Surgery Center at 406 327-3300. Fax number is 406 327-3302.