Billings Clinic

For internal use only:

MRN:_____

Health Information Management- Release of Information
P.O. Box 31598, Billings, MT 59107
PHONE (406) 657-4676 FAX (406) 657-4348
E-MAIL roih@billingsclinic.org

Patient Request to Access Health Care Information

Patient Name: _____ **Date of Birth:** _____/_____/_____

Requesting Medical Records From:

- ☐ Billings Clinic (Billings, Miles City, Cody, Bozeman OB/GYN)
- ☐ Red Lodge Clinic (Prior to November 18, 2010)
- ☐ Stillwater Billings Clinic
- ☐ Psychiatric Center / Behavioral Health Clinic
- ☐ Bozeman/Acorn Pediatrics
- ☐ Columbus Clinic (prior to September 10, 2012)

Specific information being requested:

- ☐ Hospital Medical Records
- ☐ Clinic Medical Records
- ☐ Immunization Records
- ☐ Psychiatric Records
- ☐ Imaging Disc
- ☐ Billing Records
- ☐ Other_____

☐ Specific Date(s):_____ to _____ **If no dates are specified, the last two (2) years will be released.**

Format requested: *a disc will be mailed if no format is selected

- ☐ No records sent at this time/Verbal use only. Please keep on file.
- ☐ Electronic – E-mail (Size limit applies. If too large to e-mail, a disc will be mailed). **Health information sent via unencrypted email may place risk of inappropriate access to the information contained within e-mail. I accept the risk of this if I direct Billings Clinic to send my health information via unsecure means.**
- ☐ Electronic – Disc
- ☐ Electronic – Fax
- ☐ Paper Format - Mail
- ☐ Pick up in person (If not picked up in 14 days, records will be mailed.)

Send Information to:

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: (_____) _____ **Fax:** (_____)_____

E-mail Address (if format requested above): _____

Expiration Date: ☐ 6 months ☐ 1 year ☐ Other _____

Patient/Authorized Representative* Signature: _____ **Date:** _____
*If signed by a patient's authorized representative, supporting legal documentation must accompany this authorization form.

Printed Name of Authorized Representative: _____ **Relationship to Patient:** _____