HELENA
Direct Primary Care

Release of Information

Patient
Patient Name:_____ DOB_____/_____/_____
Address_____ City _____
State:_____ Zip Code _____ Phone:(____) ____-_____

Information Requested From
Name _____ Address _____
City _____ State _____ Zip Code _____
Phone (____) ____-_____ Fax (____) ____-_____

Information Requested
__ Chart Notes
__ Labs
__ Imaging Reports
__ Immunization Record
__ Surgical/Procedure Records
__ Other

Send Information To
Name: Helena Direct Primary Care
City: Helena State: Montana
Phone: (406) 389-8045
Email: mishaila@helenadpc.com
Address: 2735 Colonial Drive Suite B
Zip Code: 59601
Fax: (406) 389-4616

Consent
I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that the information in my medical record may include information relating to sexually transmitted diseases, AIDS, or HIV. It may also include information about behavior or mental health services, and treatment for alcohol and drug abuse. I understand that if I revoke this authorization I must do so in writing and present my written revocation. I understand that my revocation will not apply to information that has already been released in response to this authorization.

Printed Name: _____ **Signature:** _____ **Date:** _____