Dr. Kellyn Milani
602 S. Ferguson Ave, Suite 4
Bozeman, MT 59718
406-624-6284
406-548-9755
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RELEASE OF RECORDS FROM REMEDY HEALTH

This release must be completed or it cannot be used to send information to outside entities. Please complete all lines of the form. Records requests may take three to four weeks to process depending on the entity.

Patient Name: ____________________ **Patient DOB:** ____________________

Please release client information TO:

Name of Clinic/Doctor Releasing TO : ____

Address of Clinic/Doctor: ______________________________

Phone of Clinic/Doctor :_________________________

Fax of Clinic/Doctor: ____________________

Name of Clinic/Doctor Releasing FROM: Remedy Health, Dr. Kellyn Milani

Address of Releasing Clinic/Doctor: 602. S. Ferguson Ave, Suite #4, Bozeman, MT 59718

Phone: 406-624-6824 **Fax of Releasing Clinic/Doctor:** 406-548-9755

I hereby authorize the Remedy Health/Dr. Kellyn Milani to release the following information during the period of

(beginning date) ____________________ to (ending date) ____________________

Information to be Released:

Any and ALL Records (includes ALL types of records listed below. If you want to include films/images please check that box below)

☐ Yes, release ALL records

ONLY release records types checked below:

☐ Office visit notes ☐ Laboratory/Diagnostic reports ☐ Treatment Plan ☐ Surgical notes ☐ Radiology reports

Check yes/no to release other records typed in next box:

☐ Yes ☐ No

Other records to release (please type here):

____

If the information used or disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information WILL NOT BE disclosed if I place a check mark in the applicable space next to the type of information:

☐ Drug/Alcohol diagnosis, treatment, or referral information ☐ HIV/AIDS information ☐ Genetic Testing Information

Date information is needed by:

____

Purpose of Release of Information:

☐ Continuing care ☐ Transfer of care ☐ Litigation/legal ☐ Personal use or review.

This authorization may be cancelled in writing at any time. A cancellation will not change release that happen before the cancellation. Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

Patient Full Name	Patient Signature	Date
Authorizing Party Full Name	Authorizing Party Signature	Date