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 TO REMEDY HEALTH

This release must be completed in it's entirety to receive information from outside entities. This is a records release form for records to be sent TO Remedy Health FROM an OUTSIDE doctor/clinic. ALL RECORDS CAN TAKE UP TO 3 WEEKS TO RECEIVE DEPENDING ON THE ENTITY. If you need additional records request forms please contact our office. Records may be faxed or mailed to our clinic. Below is our contact information.

Please release client information TO:

Name: Remedy Health, Dr. Kellyn Milani	**Phone:** 406-624-6824	**Fax:** 406-548-9755
Address: 602 S. Ferguson Ave, Suite #4	**City/State:** Bozeman, MT	**ZIP:** 59718

Patient Name: _____ **Patient DOB:** _____

Name of Clinic/Doctor Releasing TO Remedy Health: _____

Address of Releasing Clinic/Doctor: _____

Phone: _____

Fax of Releasing Clinic/Doctor: _____

I hereby authorize the releasing clinic/doctor to release the following information during the period of

(beginning date) _____ to (ending date) _____

**The beginning date should be either the date you started seeing the provider for an ALL records, or the date of the office visit/lab result when requesting specific records.*

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 ☐ Yes, release copies of films/images

ONLY release records types checked below:

☐ Office Visit Notes ☐ Laboratory reports ☐ Diagnostic reports ☐ Operative reports
☐ Radiology reports ☐ Progress notes ☐ EKG/Cardiology reports

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

☐ Yes ☐ No

Other types of records to be released (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 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

☐ Mental Health Information ☐ Genetic Testing Information

Date information is needed by:

_____

Purpose of releasing 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 (Parent/Guardian) Full Name	Authorizing Party (Parent/Guardian) Signature	Date