MOVING MOUNTAINS
THERAPY CENTER
KEEP CLIMBING

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____Address:
_____

Telephone: (Home): _____ (Work): _____ (Other): _____

AUTHORIZE:	AUTHORIZE:
_____	_____
Name of Physician/Facility	Name of Physician/Facility
_____	_____
Street Address	Street Address
_____	_____
City, State, Zip Code	City, State, Zip Code
_____ _____	_____ _____
Telephone Fax	Telephone Fax

EXCHANGE RECORDS WITH: Moving Mountains Therapy., PLC, Missoula, MT 59801
Phone: 406-396-4130, Fax: 406-797-5008

Information to be Released:

Date Range: From: _____ to _____

- ☐ All medical records
- ☐ Physician Notes
- ☐ Rehabilitative Therapy (PT, OT, ST)
- ☐ Hospital Records
- ☐ Other: _____
- ☐ Lab Results
- ☐ X-ray Reports
- ☐ X-ray films/CD/DVD
- ☐ Psychological/Psychiatric/Counseling Records

Reason for Disclosure:

I would like this information released for the following purpose:

- ☐ Continued care by another provider
- ☐ Insurance purposes
- ☐ Attorney
- ☐ Social Security Disability

I have read and understand the following:

- This authorization expires one year after I sign it or sooner (specify here: _____). The time period noted here may exceed one year only in certain situations specified by law.
- I may revoke this authorization at any time by notifying the facility in writing. This authorization will cease to be effective on the date notified. This will not apply to records that have already been released.
- The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specifically protected information. Once the records are released, Advanced Speech Therapy, Inc. cannot prevent them from being released to a third party.
- There may be a fee for releasing these records.
- To be valid, this authorization must be filled out completely and signed. A copy is valid if it has not been altered.
- If I do not sign this authorization, my healthcare and payment for my healthcare will not be affected, and will not jeopardize my right to obtain present or future treatment, except where disclosure of the information is required for the treatment.

_____ _____

_____

Signature of patient or authorized person Authorized person's authority to sign Date

(If authorized person is signing, please also print name) (parent, guardian, power of attorney, etc.)REASON PATIENT IS UNABLE TO SIGN: ☐ Minor ☐ Disability ☐ Other: