ERIC R. DRINGMAN, M.D., F.A.C.S.
KATHRYN F. HATCH, M.D., F.A.C.S.
BARRY A. McKENZIE, M.D., F.A.C.S.
RACHEL L. OTT, M.D., F.A.C.S.

SURGICAL ASSOCIATES PC
2900 12th Ave North, Suite 355W, Billings, MT 59101
(P) 406-238-6470 / (F) 406-238-6499
www.billingssurgeons.org

GEORGE K. BENTZEL, M.D., F.A.C.S.
JEFFREY J. RENTZ, M.D., F.A.C.S.
MICHAEL G. WILCOX, M.D., F.A.C.S.

AUTHORIZATION FOR RELEASE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient's Full Name: _____DOB: _____

Maiden/Previous Name(s): _____SSN: _____

Address: _____City: _____State: _____Zip: _____

Home Phone: _____ Cell Phone: _____

Release From: **SURGICAL ASSOCIATES, PC**for the following purpose (check one):

___ at the request of the individual ___ other (specify) _____

Release To: _____
(Name of Individual or Agency)

Address: _____City: _____State: _____Zip: _____

Phone: _____ Fax: _____

Information to be Released/Disclosed (check all that apply):

___ Operative Report ___ Lab/Pathology Results _____
___ Consult/Progress Notes ___ X-Ray/ImagingReports _____
___ History &Physical ___ Other _____

From Dates of Service Starting on:_____and Ending on:_____
(Month/Day/Year) *(Month/Day/Year)*

I Understand the Following:

- Without my express revocation, this authorization will automatically expire 24 months from the date signed below, unless I request an expiration date less than 24 months.
- I may revoke this authorization in writing at any time, except to the extent that action has already been taken to comply with it.
- Information disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and is no longer protected by the Privacy rule.
- A signature is required to validate this authorization. If I do not sign this authorization, this Care Site will still provide treatment and seek payment for services provided.
- I can request a copy of this authorization after it is signed.

Patient/Guardian Signature:_____**Date:** _____

If this authorization is not signed by the patient complete the following:
Printed Name: _____Relationship to Patient: _____