



Your trusted source for sexual healthcare & education.

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Authorization for Health Record Transfer

Date Reason for transfer:

Patient name:

Date of Birth: S.S.#: Med.Rec.#:

I AUTHORIZE BRIDGERCARE TO REQUEST RECORDS FROM / RELEASE RECORDS TO: (circle one)

Name:

Address: City: State: Zip:

Phone: Fax:

I SPECIFICALLY AUTHORIZE RELEASE OF THE FOLLOWING RECORDS:

Entire Medical Record, OR (check appropriate box)

LATEST RESULTS:

Dates:

- History and physical exam
Progress notes
Substance abuse (including alcohol/drug abuse)
Lab reports: Chlamydia GC PAP Other
HIV related information (AIDS related testing)
Prescription type/ dosage -- specify:
Mental Health
Ultrasound/ Mammography reports
Colposcopy and other related pap follow-up records
Other:

Conditions of Authorization

- This authorization will expire one year from the above date of request or on specified date.
I may revoke this Authorization at any time by notifying Bridgercare in writing, and it will be affective on the date notified except to the extent that Bridgercare has already acted upon such Authorization.
Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.

Signature of Patient OR Parent/ Legal Guardian Date

Signature of Staff OR Witness Date