HELENA PEDIATRIC CLINIC, P.C.
1122 N. MONTANA AVE.
HELENA, MT 59601
PHONE 406-449-5563
FAX 406-449-4730

ERIN GREEN, D.O.
MICHAEL S. PALCISKO,M.D.
TERESA AUGUSTINE, M.D.
CALLIE N. RIGGIN, M.D.
JAMES C. LAMAR, M.D.
JESSICA SMITH, D.O.

RECORDS TRANSFER REQUEST

DATE:_____

CHILD'S LAST NAME_____FIRST NAME_____DOB_____

PARENT'S LAST NAME_____FIRST NAME_____DOB_____

ADDRESS_____SOCIAL SECURITY #_____

CITY_____STATE_____ZIP_____PHONE_____

I AUTHORIZE THE FOLLOWING FACILITY TO RELEASE:

FACILITY/CLINIC_____ □ ALL MEDICAL RECORDS

ADDRESS_____ □ ONLY DATES FROM_____

CITY_____STATE_____ZIP_____ □ OTHER(SPECIFY)_____

PHONE#_____FAX#_____

PLEASE SEND THE INFORMATION TO:

FACILITY/CLINIC/PERSON_____

ADDRESS_____

CITY_____STATE_____ZIP_____

FAX INFO □YES □NO FAX#_____ATTN_____

PURPOSE OF MEDICAL RECORDS RELEASE_____

I UNDERSTAND THAT THIS AUTHORIZATION MAYBE REVOKED BY ME AT ANYTIME, PROVIDED THAT I DO SO IN WRITING PRIOR TO THIS RELEASE HAVING ALREADY BEEN DONE. I ALSO UNDERSTAND THAT MY PROTECTED HEALTH INFORMATION MAYBE DISCLOSED BY THE RECIPIENT AND IS NO LONGER PROTECTED UNDER FEDERAL LAW. THIS AUTHORIZATION WILL EXPIRE IN 6 MONTHS, UNLESS STATED OTHERWISE.

PATIENT SIGNATURE(IF OVER 18)_____DATE_____

PARENT/LEGAL GUARDIAN SIGNATURE_____DATE_____

RELATIONSHIP TO CHILD_____

********IF MEDICAL RECORD IS OVER TEN PAGES PLEASE MAIL. THANKS!**