YELLOWSTONE SURGERY CENTER
P.O. Box 31715
Billings, MT 59107
(406) 237-5900
www.yscmt.com

Authorization for Release of Confidential Patient Information

I hereby authorize Yellowstone Surgery Center to disclose my health information as described below:

_____	_____	_____
Patient Name	**Date of Birth**	**Phone Number**

Information Requested:
I request the following records from my medical record for date(s) of service_____
(Please circle): Operating Room Record History & Physical Nurses Notes Physicians Orders
Complete Medical Record Other (please specify):_____

Reason for Disclosure: (please circle):
Continued care by another provider Disability Determination Insurance Claim
Other (please specify):_____

Name and address of person to receive the records: _____
_____
_____

This authorization expires 90 days from the date of my signature.
I understand I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken in reliance thereon. This consent will expire automatically 90 days from the date of execution. Records released under this authorization shall not be considered part of the records of the receiving facility. Any further disclosure of medical record information by the recipient is not authorized without the specific written consent of the person to whom it pertains.

The undersigned is (check appropriate line):
_____ Patient
_____ Patient's legal representative
(please specify):_____
_____ Other
(please specify):_____

Contact information of person requesting if different than patient:
_____
_____
_____
Phone: _____

Signature: _____ Date: _____
Printed name: _____

All Fields must be completed
*** Normal turnaround time for disclosing records is 30 business days from record completion date***

RESERVED FOR OFFICE USE ONLY:
Identification (circle): Driver's License viewed? Y / N Signature verified? Y / N MRN: _____
Verified by:_____ Date:_____

Release Date: _____ # of pages: _____ Mailed / Faxed
Released by:_____

Picked up by_____
Signature:_____ Date:_____