MONTANA CHIROPRACTIC LEGAL PANEL

2021 Eleventh Avenue, Suite 1 · Helena, MT 59601-4890
Telephone (406) 443-1110 · Fax (406) 443-4042

Authorization for Release of Medical Information

I hereby authorize:

Health care provider or facility _____

_____
Mailing address City State Zip

To release medical records obtained during the course of treatment of

Patient Name _____ Date of Birth _____

_____
Mailing address City State Zip

Dates of records to be released: _____
Starting Date Ending Date

Pursuant to Section 27-12-302(2) MCA, the undersigned hereby authorizes the Montana Chiropractic legal Panel to obtain access to all claims for treatment, medical and hospital records and information pertaining to the claim. I understand that this Authorization extends to all or any part of the records information which may include treatment for physical and mental illness, alcohol/durum abuse, sexually transmitted diseases and HIV/AIDS test results of diagnoses. I authorize the above named person, health care provider, hospital or health care facility to deliver any and all such information or copies thereof to the Director of the Montana Chiropractic Legal Panel or authorized agent.

The treatment dates covered by this Authorization include all dates of treatment. The undersigned waives any privilege as to the contents of those records for the purposes of consideration by the Montana Chiropractic Legal Panel only, which includes distribution of the records to the chiropractic physician(s) named in the claim before the Panel, or their attorneys and the members of the Panel sitting in hearing on the above claim. Nothing in this statement shall in any way be construed as waiving that privilege for any other purpose or in any other context, in or out of court.

In any event, I may revoke this Authorization at any time, except to the extent that action has been taken in reliance thereon. Authorization will automatically expire 120 days from the date claim received by the Panel. I hereby release the Montana Chiropractic Legal Panel from all legal responsibilities or liability that may arise from disclosure of medical records in reliance on this Authorization. (If patient is a minor, both the patient and a parent or legal guardian must sign the Authorization.)

Patient Signature _____ Date _____

Print Name _____

Witness _____ Date _____

Parent/Legal Guardian _____ Date _____