Magic City
FAMILY MEDICINE

Release of Information to Magic City Family Medicine

Patient Name (Please Print) _____Date of Birth _____

I hearby authorize:	To release information to:	Patient address:
	Magic City Family Medicine	
	907 Wyoming Ave, Ste 901	
	Billings, MT 59101	
Phone:	Phone: 406-558-3458	
Fax:	Fax: 855-576-4937	Phone:

Information Requested:

Complete Chart _____

If not requesting complete chart, please indicate the information you are requesting:

Circle All Applicable

Doctor's Notes	Lab Reports	Mental Illness,
Psychiatric Treatment	X-Ray Reports	Immunization Records
Drug or Alcohol Abuse	HIV	Other (Please Specify)

If only certain items are requested, please specify the dates of care:

Reason for record transfer:

I request and authorize to release the specific information to the individual named on this request. I am aware that this information may also include my current or past residences. Any patient 18 years of age or older must sign for their own records.

Signature of Patient: _____Date: _____

This form is being provided as a courtesy to our patients. It is the sole responsibility of the patients to obtain their medical records from previous physician offices.