An Intermediate / Skilled Care Facility
2000 Montana Avenue • Glendive, Montana 59330
Ph. (406) 345-8855 • Fax (406) 345-8121

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date_____ Time_____

I, _____ authorize and request that

_____
(Name and address of the hospital and/or physician)

Hospital/clinic and the physicians who attended to me while I was a patient in the said hospital/clinic during the approximate period from _____ , _____, to _____, _____, will furnish to Eastern Montana Veterans Home all information concerning my case history, treatment, examination and/or hospitalization. This will include copies of hospital and medical records for the above the time period.

I hereby certify that I have read and fully understand the above Authorization for Release of Medical Records.

_____ Date _____
Signature of Applicant or Authorized legal representative

_____ Date _____
Witness Signature

Authorization must be signed by the patient, responsible relative or legal guardian, if appointed.