



RECORDS RELEASE FORM

*Please submit records electronically,
via fax (406-285-6742) or email (contact@threeriversmedicalclinic.net).*

Patient Name

Date of Birth

Previous Patient Name(s)

Current Patient Address

Previous Patient Address

I hereby authorize the release of my medical records including mental health records from:

Dates of DIGITAL Records Requested:

From _____ To _____

Office Name

Provider Name

Office Address

Office Phone(s)

Office Fax

Patient Signature

Date

Witness Signature

Date

Three Rivers Medical Clinic

Three Forks, Montana 59752

Phone: (406) 285-3251 • Fax: (406) 285-6742

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