Three Rivers
MEDICAL CLINIC

# RECORDS RELEASE FORM

## Please submit records ***electronically***

via fax (406) 285-6742 or email frontdesk@threeriversmedicalclinic.net

Patient Name _____ Date of Birth _____

Previous Patient Name(s) _____

Current Patient Address _____

Previous Patient Address _____

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**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 _____

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Patient Signature _____ Date _____

Witness Signature _____ Date _____

**Three Rivers Medical Clinic**
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frontdesk@threeriversmedicalclinic.net