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
contact@threeriversmedicalclinic.net

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