GREAT DIVIDE
PHYSICAL THERAPY

2819 Great Northern Loop, Suite #300
Missoula, MT 59808
406-317-1121 (Office)
406-317-1875 (Fax)
www.greatdividept.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

NAME: _____ **BIRTHDATE:** _____

SSN: _____

I request and authorize _____
to release healthcare information of the patient named above to:

Great Divide Physical Therapy
2819 Great Northern Loop, Suite #300
Missoula, MT 59808
406-317-1121 (Office) 406-317-1875 (Fax)

This request and authorization applies to:

☐ All healthcare information

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ Imaging report

☐ Surgical report

☐ Other: _____

_____

PATIENT SIGNATURE: _____ **DATE SIGNED:** _____

This authorization expires in ninety (90) days.