1216 16th St. W. · Alpine Village Suite 21 · Billings, MT 59102 · (406) 969-4340 · www.PicturePerfectUltrasound.com

# Medical Records Release Form

By signing this form, I authorize *Picture Perfect Ultrasound* to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: _____ Date of Birth: _____

Release my protected health information the following physician/person/facility/entity and/or those directly associated in my medical care:

Name: _____
Attention To: _____
Fax Number: _____
Phone Number: _____
Address: _____
City: State: Zip Code: _____

Patient Name: _____

Signature of Patient ***or*** Personal Representative:

_____

Relationship to Patient: _____

Date: _____