# REQUEST FOR MEDICAL RECORDS

**DATE OF REQUEST:** _____

Name of Doctor/Clinic/Hospital that records are being released from: _____

_____

## SEND THE FOLLOWING RECORDS/REPORTS/FILMS:

☐ Medical/Chiropractic Records (Recent records only) Do not include billing records.
☐ Medical/Chiropractic Records (All past records) Do not include billing records.
☐ X-ray report and films _____
☐ MRI report/films
☐ CT report/films
☐ EMG, SSEP, and Nerve Conduction Study Reports
☐ IME report
☐ Other _____

## SEND RECORDS TO:

The following Doctor/Office has authorization from this patient to request release of medical records to:

**Montana Wellness Center**
**670 King Park Drive Suite 1**
**Billings, MT 59102**
**406-655-4940 Fax 406-655-4944**

## PATIENT INFORMATION

| |
|---|
| Patient Name (Print): |
| Social Security No: |
| Date of Birth: |
| Medical Record No: |

I, _____, hereby request and authorize the above records and tests to be released and mailed to the doctor/facility indicated at the top of this form. It is understood that any X-ray, CT, or MRI original films will be returned to the originating facility within 30 days after receiving them.

Signature of Patient: _____ Date: _____