



Rocky Mountain

# SURGICAL SOLUTIONS

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## **CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION**

By signing this form, you are authorizing Rocky Mountain Surgical Solutions to release otherwise confidential information to one or more people whom you designate. Please read carefully. We will gladly answer any questions.

I authorize Rocky Mountain Surgical Solutions to:

- Discuss otherwise confidential information pertaining to my account history

I authorize the release of the information specified above to:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Any restrictions or limitations to be released (please specify)

\_\_\_\_\_

- No limitations

I understand that I do not have to agree to release confidential information, and that I may withdraw this consent at any time.

Name(printed): \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_