Western Montana Clinic

Authorization for Release of Individually Identifiable Health Information to Designated Party

PATIENT LABEL HERE

Patient Last Name	First Name	MI	Date of Birth	Social Security Number

This authorization grants permission to the designated party (ies) named below to all of the following:

- Make or confirm appointments
- Verbal access to x-ray, laboratory, test findings, diagnosis, prognosis and treatment plans by telephone or other common means of communication
- Pick up sample medications
- Access to my financial health information

I hereby authorize **Western Montana Clinic** to use and disclose my individually identifiable health information as described above. The following lists of people are the people I have designated to receive my individually identifiable health information. I understand that this authorization is voluntary. I understand that once this information is disclosed to the designated party (ies) named below, the release of information may no longer be protected by federal privacy regulations. I understand an authorization for release of information will need to be signed if a photocopy of my medical record is required.

PLEASE PRINT THE INFORMATION BELOW:

Name	Relationship	Address	Telephone

I understand that this authorization will be effective for the lifetime of the patient unless revoked in writing ***OR*** expires on _____.

I understand that I may revoke this authorization at any time by notifying the Medical Records Department in writing; however, the revocation will have no effect on disclosures made prior to the receipt of the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization.

I authorize messages to be left on my phone regarding my protected health information.

☐ Yes ☐ No

As a service to our patients, we provide a courtesy appointment reminder call/text and possibly other important calls/texts that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls/texts at this number.

☐ Yes ☐ No

_____ _____
Signature of Patient Date

_____ _____ _____ _____
Printed Name of Patient's Legal Representative Relationship Signature of Patient's Legal Representative Date