



**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION**  
**"FROM"**

Date: \_\_\_\_\_ Authorization # \_\_\_\_\_  
 Patient Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

PHONE: 406.862.2515  
 FAX 1: 406.862.0726  
 FAX 2: 406.862.4229

**Information to be released FROM:**

Glacier Medical Associates  
 1111 Baker Avenue  
 Whitefish, MT 59937

Disclosure Method  
 Pickup     Mail  
 Fax # \_\_\_\_\_  
 Other: \_\_\_\_\_

This information may be given to and used by the following individual or organization.

**I hereby request and authorize you to release information TO:**

Clinic: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I authorize the use or disclosure of the above named individual's health information as described below. Information to be released:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> All Records of Treatment from _____ to _____ | <input type="checkbox"/> Medication Record  | <input type="checkbox"/> Allergy List             |
| <input type="checkbox"/> Entire (Complete Record)                     | <input type="checkbox"/> Physician's Orders | <input type="checkbox"/> X-ray Reports            |
| <input type="checkbox"/> History & Physical Report                    | <input type="checkbox"/> Progress Notes     | <input type="checkbox"/> Drug/Alcohol Information |
| <input type="checkbox"/> Consultation Report                          | <input type="checkbox"/> Lab Results        | <input type="checkbox"/> Psychiatry Information   |
| <input type="checkbox"/> Operative Report                             | <input type="checkbox"/> HIV Results        | <input type="checkbox"/> Other                    |
| <input type="checkbox"/> Immunization Record                          |   |   |

- I understand that the information in my health record may include information relating to sexually transmitted disease, behavioral or mental health services, and treatment for alcohol and drug abuse.
- I understand there will be a charge for copying records that will be paid prior to receiving my health record.
- I understand that the above-listed item or information in Clinic's possession may have been generated by Clinic or by any other source and may be released to the above-listed Clinic.
- I understand that if the person or entity that receives the information is not a healthcare provider or a health plan covered by federal privacy regulations the information described above may be re-disclosed and no longer protected by these regulations.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in the federal privacy regulations. If I have questions, I can contact Clinic's Privacy/Security Officer.
- Unless otherwise revoked, this authorization will expire on the following date, event, or condition: \_\_\_\_\_ (maximum of 30 months). If I fail to specify an expiration date, event or condition, this authorization will expire in six months in accordance with MCA 50-16-527.
- I understand that I may revoke this authorization in writing at any time by contacting Clinic's Privacy Officer.
- I understand that this revocation does not apply to information that has already been released in response to this authorization.
- Failure to sign this authorization:
  - Will have no adverse impact on delivery of care or reimbursement of patient charges.
  - Will have the following adverse impact:
- I certify that I have received a signed copy of this authorization.

\_\_\_\_\_  
 Signature of Patient or Legal Guardian

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 If signed by Legal Representative, Relationship to Patient

\_\_\_\_\_  
 Signature of Witness

For Office Use Only: Copied by: _____	<input type="checkbox"/> Check ID    Type: _____ Date Copied/Sent: _____	Amount Received: _____
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I revoke (cancel) this Authorization to Disclose Health Information previously signed on \_\_\_\_\_ (date).

Cancellation Signature: \_\_\_\_\_ Date: \_\_\_\_\_