PATIENT NAME_____ **DOB**_____

Acknowledgment receipt of Notice of Privacy Practices

I acknowledge that I have been offered access to the Clinic Notice of Privacy Practices. I understand that the Notice of Privacy Practices describes how Clinic may disclose and use my protected health information. **Initial** _____

If not signed, state reason and efforts made to have acknowledgment signed.

_____

Consent to Obtain External Prescription History

I hereby authorize Glacier Medical Associates to review my external prescription history. **Initial** _____

I DO NOT authorize this access: _____Date:____/____/_____

Authorization to Disclose Protected Health Information:

This information may be given to and used by the following individual(s) or organization(s).
I hereby request and authorize you to release information TO:
Name(s): _____Relationship:_____Phone:_____

Name(s): _____Relationship:_____ Phone:_____

I authorize the use or disclosure of my health information as described below. Information to be released:

❑All Records of treatment from _____to _____

❑Entire (Complete Record)	❑Medication Record	❑Allergy List	❑Operative Report
❑History & Physical Report	❑Physician's Orders	❑X-ray Reports	❑Lab Results
❑Consultation Report	❑Progress Notes	❑Drug/Alcohol Information	❑Psychiatry Information
❑Immunization Record	❑HIV Results	❑Other	

- 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 individual or 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: GMA will be unable to release information or discuss the financial aspects of your account with anyone other than you.

I certify that I have read and understand this authorization, and that a copy of the signed document has been offered to me.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
If signed by Legal Representative, Relationship to Patient Signature of Witness

I revoke (cancel) this Authorization to Disclose Health Information previously signed on _____ (date).

Cancellation Signature: _____ Date: _____