AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Date: _____

Patient Name: _____ Date of Birth: _____ SSN: _____
Information to be released from:

Name: _____
Address:_____
_____

Disclosure Method:
☐ Pickup ☐ Mail
☐ Fax # _____

This information may be given to and used by the following individuals or organization.
I hereby request and authorize you to release information **TO**:

GLACIER EYE CLINIC, P.C.
175 Timberwolf Pkwy, Kalispell, MT 59901 Ph: 406-257-2020 Fax: 406-257-5554
Aaron M Alme, MD ~ Roger A Barth, MD ~ Mark Goerlitz-Jessen, MD
Tyler Ofstad MD, PhD ~ Mark Remington, MD ~ Gus Stein, MD
Mackenzie Fai, OD ~ Jonathan Olsen, OD ~ Marie Roach, OD

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

☐ Most Recent Records (Last 3 exams)

☐ Entire (Complete Record)	☐ Immunization Record	☐Allergy List
☐ Specific Dates _____ to _____	☐ Medication Record	☐ X-ray Reports
☐ History & Physical Report	☐ Physician's Orders	☐ Drug/Alcohol Information
☐ Consultation Report	☐ Progress Notes	☐ Psychiatry Information
☐ Operative Report	☐ Lab 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 may be a charge for copying records.
- I understand the above listed item or information in Clinic's possession may have been generated by Clinic and may be released to the above listed Clinic.
- I understand that all health care information in your possession, whether generated by you or by any other source, may be released to me or the above-named clinic.
- I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulation, 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.
- Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.
- I understand that I may revoke this authorization in writing at any time by contacting Glacier Eye Clinic, 406-257-2020.
- I understand that this revocation does not apply to information that has already been released in response to this authorization.

_____ _____
Signature of Patient or Legal Representative Date

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

Date Sent:	Date Sent:
Initials:	Initials: