GREAT FALLS HOSPITAL GREAT FALLS CLINIC

Great Falls Clinic-Northwest	Great Falls Clinic-Main	Hospital & Specialty Clinics	Surgery Center
1600 Division Road	1400 29th Street South	3000 15th Avenue South	1509 29th Street S
Great Falls, MT 59404	Great Falls, MT 59405	Great Falls, MT 59405	Great Falls, MT59405
(406-268-1600)	(406) 771 3106	(406) 216 8070	(406) 771-3538

AUTHORIZATION FOR RELEASE OF INFORMATION

PROOF OF IDENTIFICATION IS REQUIRED TO OBTAIN RECORDS

I authorize the following facility(s): ☒Great Falls Clinic ☒Great Falls Clinic Hospital to release the protected health information of:

Name of Patient:			DOB:		Phone:		
Address:		City/State:			Zip:		

TO FOLLOWING INDIVIDUAL OR ORGANIZATION:

Facility/ Name of Person:	SELF	
Address:		
Phone #		Fax #

REASON FOR REQUEST: ☒Personal ❑Legal Review ❑Continuity of Care ❑Disability ❑OTHER _____

DATES OF SERVICE _____ to _____ **❑ MAIL ❑ PICKUP ❑ FAX**

INFORMATION REQUESTED: *Please note – State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained. *

*____ *(Initials)* Alcohol/Drug Abuse Treatment *____ *(Initials)* HIV/AIDS Diagnosis & Treatment
*____ *(Initials)* Psychotherapy

☒All Medical Record(s) (excludes billing) or specifically those parts checked below:

❑Discharge Summary	❑History and Physical Exam	❑Operative Report
❑Consultations	❑Progress Notes	❑Radiology Results
❑Laboratory Tests	❑Pathology Report	❑Immunizations
❑ER Notes	❑Office Visit Notes	❑Photos/Imaging

❑Abstract/ Summary (Includes Discharge Summary, History & Physical Exam, Operative Report(s), Consultations and Test Results)
❑Other (please specify) _____

This authorization will expire on this date or event: _____

- I understand, unless revoked, if no date or event is specified, this authorization will expire 12 months from date signed. Authorization is for the information requested above and does not pertain to future dates of service.

YOUR SIGNATURE BELOW CONFIRMS YOU UNDERSTAND AND AGREE TO THE TERMS OUTLINED.

- I understand that this authorization may be revoked in writing at any time by submitting a request to the Health Information Management (HIM) Department at: 2000 26th Street South Great Falls, MT 59405 or email: medicalrecords@gfclinic.com. Contact the HIM Department at (406) 771-3106 for further instructions
- I understand that treatment, payment, enrollment or eligibility benefits may not be affected by me signing this authorization unless allowed by Federal Privacy Laws.
- I understand that if there is disclosure of this information by the recipient, it may no longer be protected by the Federal Privacy Laws.

If this authorization is signed by a legal/personal representative (other than a parent or legal guardian for a minor), please describe your authority to act for the individual (e.g., power of attorney, legal guardian, executor):

PATIENT OR LEGAL REPRESENTATIVE (Print Name) _____ DATE _____
PATIENT OR LEGAL REPRESENTATIVE (Sign Name) _____
Description of Representative's Authority: _____

PARENTAL REQUEST FOR CHILD'S MEDICAL RECORDS

I hereby declare under penalty of perjury, that I am the natural or adoptive parent or legal guardian of said child and there is no court order restricting or prohibiting my access to such medical records.

PARENT OR LEGAL GUARDIAN (Print Name) _____ DATE _____

PARENT OR LEGAL GUARIDAN (Sign Name) _____