Great Falls Clinic, LLP

(406). 454.2171 FAX (406).771.3047

PLEASE ALLOW 30 DAYS FOR PROCESSING

Great Falls Clinic - Main Clinic · 1400 29th Street South · Great Falls, MT 59405
Great Falls Clinic - Immediate Care · 1400 29th Street. S. · Great Falls, MT 59405
Choteau Clinic · 124 Main Ave N · Choteau, MT 59422
Helena Physicians' Clinic · 3330 Ptarmigan Lane · Helena, MT 59602
Mercury Street Medical Group · 300 West Mercury · Butte, MT 59701

Great Falls Clinic -**Northwest Clinic** · 1600 Division Road · Great Falls, MT 59404
Great Falls Clinic - **Marketplace** · 2012 14th Street SW · Great Falls, MT 59404
Fairfield Clinic · 324 Central Avenue · Fairfield, MT 59436
Specialty Center · 3000 15th Avenue South · Great Falls MT 59405
Focused MedCare · 3703 Harrison Avenue · Butte, MT 59701

AUTHORIZATION FOR RELEASE OF INFORMATION

IMPORTANT: READ ALL INFORMATION & INSTRUCTIONS ON BOTH PAGES OF THIS FORM BEFORE SIGNING

Name Of Patient:_____ DOB:_____ Phone: _____

Address_____ City/State _____ Zip Code_____

Are medical records filed under a different name? _____

TO MAIL

DATE NEEDED_____ **TO PICKUP**

I HEREBY AUTHORIZE THE GREAT FALLS CLINIC TO RELEASE MEDICAL INFORMATION TO:

Name _____

Address_____ City/State _____ Zip Code_____

REASON FOR REQUEST:

Personal	Legal Review	New Employer
Transfer of Care	Disability	Life Insurance
Billing Information Only	Referral	OTHER (please explain)

INFORMATION REQUESTED:

All Medical Records (does not include alcohol/drug abuse treatment, psychotherapy notes, or HIV/AIDS diagnosis & treatment)

Lab	Immunizations	____ *(Initials)* Alcohol/Drug Abuse Treatment
Progress notes	Radiology Reports	____ *(Initials)* Psychotherapy Notes
Correspondence	Radiology Images	____ *(Initials)* HIV/AIDS Diagnosis & Treatment

Other _____

DATES OF SERVICE_____ **TO** _____

This authorization expires in 30 months or:

EXPIRATION DATE_____ (If you wish the authorization to end earlier than 30 months, specify a date.)

EXPIRATION EVENT _____ (Event must relate to the individual or the purpose of the disclosure.)

The undersigned understands this authorization may be revoked at any time upon written notification to the Great Falls Clinic Medical Records Department except to the extent that the Great Falls Clinic has already taken action on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

In accordance with Great Falls Clinic Operating Policy and Procedure, Protected Health Information (PHI) shall be disclosed upon receipt by the clinic of a valid patient authorization or other document evidencing the recipient's entitlement to receive the PHI. The undersigned understands when the Great Falls Clinic discloses information pursuant to this authorization the information may no longer be protected by federal or state Privacy Rules and may be subject to re-disclosure by the recipient of the information.

I understand that the Great Falls Clinic may not condition the provision of treatment , payment, or enrollment in a health plan, or eligibility for benefits on my failure to provide an authorization for release of my protected health information, except: 1) research related treatment, or my enrollment in a research study, may be conditioned on my execution of an authorization for the use of preexisting information, and 2) a health plan may condition my enrollment in the health plan, or eligibility for benefits, on me providing an authorization prior to my enrollment if the authorization sought is for enrollment or eligibility determinations or for the plan's underwriting or risk rating determinations, and the authorization is not for use or disclosure of psychotherapy notes.

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

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 not court order restricting or prohibiting my access to such medical records.

PARENT OR LEGAL GUARDIAN (Print Name) _____ DATE_____

PARENT OR LEGAL GUARIDAN (Sign Name) _____

PATIENT OR LEGAL GUARDIAN (Print Name)_____ DATE _____

PATIENT OR LEGAL GUARDIAN (Sign Name)_____

Explanation if signed by other than patient (i.e., parent, legal guardian or legal representative)

_____