Glacier Community Health Center / Dental Clinic

Authorization to Give and Receive Information Regarding Health Care

Patient's Name____ **DOB:**______________________________

I ______________________________________ hereby authorize and grant permission to the following person(s) to provide or request information in regards to my healthcare services:

Name	Address	Phone	Relationship to Patient
_________________	___________________	______________	______________
_________________	___________________	______________	______________
_________________	___________________	______________	______________

____I give permission to (re)schedule/cancel the following appointments:

- ____Medical
- ____Behavioral Health
- ____Dental
- ____Palliative Care

I hereby fully and irrevocably release and discharge Glacier Community Health Center from liability for all appropriate medical care provided based upon reliance on this Authorization. I understand that I may revoke this Authorization, in writing, at any time.

____

Patient Signature   Date