

**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