GCHC Authorization to RELEASE INFORMATION

GLACIER Community Health Center

Authorization for access to the records of:

Name Last	First	Middle	Date of Birth

PATIENT ID NUMBER	SS# / OTHER ID NUMBER	FORMER NAMES	LOCATION OF SERVICE

Request information FROM / TO (please circle one):

Dr. or Clinic Name:	Phone Number:	Fax Number

ADDRESS	CITY	STATE	ZIP CODE

FROM / TO (please circle one):

ORGANIZATION OR AFFILIATION

GLACIER COMMUNITY HEALTH CENTER, INC.

TELEPHONE NUMBER (INCLUDE AREA CODE)	FAX NUMBER (INCLUDE AREA CODE)	
(406) 873-5670	**(406) 873-5675**	

ADDRESS	CITY	STATE	ZIP CODE
519 E. Main St.	**Cut Bank**	**MT**	**59427**

REASON FOR RELEASE

AUTHORIZATION FOR RELEASE:

I authorize the following release of information from my records. I understand that information may be provided orally, by mail, fax, or hand delivery. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

Check all that apply:

- ☐ Medical Record
- ☐ Progress and treatment notes
- ☐ X-ray and/or Imaging Reports
- ☐ Laboratory Results
- ☐ Billing Statements
- ☐ Pathology Reports
- ☐ Prescriptions (Pharmacy records)
- ☐ Other

All records from this Date:_____

To this Date:_____

I give my permission to release the following records (Initial all that apply):

_____**HIV/AIDS and STD test results, diagnosis or treatment records MCA 50-16-1000**
_____**Genetic testing information**
_____**Mental health records**
_____**Chemical Dependency (CD) records (42 CFR Part 2)**

I understand that all health care information, whether generated by you or by any other source may be released to me or to the designated person above for the purpose given. I may revoke this release in writing at any time, but I understand that revocation will not affect any information that was already released. This consent is valid for ninety (90) days or upon expiration date stated in the authorization, whichever is earlier. A copy of this form is valid to give my permission to release records. MCA 50-16-531 GCHC may charge to provide copies of its records. MCA-50-16-816

PRINT NAME	**DATE SIGNED**	**TELEPHONE NUMBER (INCLUDING AREA CODE)**

AUTHORIZED BY (SIGNATURE)

If I am not the person whose records are being released. I am authorized to sign because I am the:

- ❑ Parent
- ❑ Legal Guardian (attach copy of court order)
- ❑ Other

To those receiving information under this authorization: Federal and state laws and regulations protect the information disclosed to you. You may not release it to any other person or entity without specific written consent. You are subject to the same standards and laws of confidentiality as the originating holder of the records.