Glacier Community Health Center, Inc.

Release of Information

Authorization to access 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):

Organization or Affiliation: **Glacier Community Health Center, Inc.**

Phone Number	**(406) 873-5670**	Fax Number	**(406) 873-5675**

Address	**519 E Main St**	City	**Cut Bank**	State	**MT**	ZIP Code	**59427**

Information FROM / TO (please circle one):

Facility or Person's Name **(1)**	Phone Number	Fax Number

Address	City	State	ZIP Code

Reason For Release

Facility or Person's Name **(2)**	Phone Number	Fax Number

Address	City	State	ZIP Code

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 benefits.

Check all that apply: (If only wanting specific people/clinics access to certain records, write number next to box)

Records From Date

Records To Date

_____ ☐ Medical Record

_____ ☐ Progress and Treatment Notes

_____ ☐ X-Ray and/or Imaging Reports

_____ ☐ Laboratory / Pathology Results

_____ ☐ Other

_____ ☐ HIV/AIDS and STD Test Results, diagnosis or treatment records MCA 50-16-1000

_____ ☐ Genetic Testing Information

_____ ☐ Behavioral Health Records

_____ ☐ Chemical Dependency (CD) Records (42 CFR Part 2)

I understand that all healthcare information, whether generated by you or by any other source may be released to me or to the designated person(s) or facilities 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. 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

Authorization to Give and Receive Information Regarding Healthcare (Appointment Scheduling Only)

I give permission to (re)schedule/cancel the following types of appointments to the person(s) listed below:

* This authorization ONLY gives permission for appointments unless specified above ↑

☐ Medical ☐ Behavioral Health ☐ Dental ☐ P2ATCH (Palliative) ☐ Other _____

Names: _____

_____

Print Name	**Date Signed**	**Phone Number (Including Area Code)**

Authorized By (Signature):	**Date to Expire:** If none written, authorization will not expire unless revoked

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 (Specify) _____

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.