DEER LODGE MEDICAL CENTER

Hospital: 406-846-2212 - Clinic 406-846-1722

1100 Hollenback Lane - Deer Lodge, MT 59722

Authorization for Release of Individually Identifiable Health Information to Designated Party

(DLMC Friends and Family Authorization Form)

Patient Last Name First Name MI Date of Birth Social Security Number (*Last four numbers*)

(INITIAL ALL THAT APPLY) **This Authorization grants permission to the designated party(ies) named below to all the following:**

_____ Make or confirm appointments

_____ Verbal access to x-ray, laboratory, test findings, diagnosis, prognosis, and treatment plans by telephone or other common means of communication.

_____ Pick up sample medications

_____ Access to my financial health information

_____ Person(s) listed have the ability to sign on my behalf for Consent for Treatment

I hereby authorize the medical practices of the Deer Lodge Medical Center to use and disclose my individually identifiable health information as described above. The following are the list of people I have designated to receive my individually identifiable health information. I understand that this authorization is voluntary. I understand that once this information is disclosed to the designated party(ies) named below, the release of information may no longer be protected by federal privacy regulations. I understand an authorization for release of information will need to be signed if a photocopy of my medical record is required.

PLEASE PRINT THE INFORMATION BELOW:

Name	Relationship	Address	Telephone **(Include area code)**

I understand that this authorization will be effective for the lifetime of the patient unless revoked in writing OR it will expire on _____.

I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, however, the revocation will have no effect on disclosures made prior to the receipt of the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization, I authorize messages to be left on my personal answering machine regarding my protected health information. _____YES _____NO

_____

Signature of Patient Date

_____

Printed Name of Patient's Legal Representative and Signature of Patient's Legal Representative Date

_____

Witness Date