



## Release of Health Information

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

Patient acknowledges and agrees that Three Rivers Medical Clinic may disclose above mentioned Patient's protected health information and patient medical record information to the following individual(s).

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_

May we leave test results on any of the following? Please initial the device(s) of your choice.

\_\_\_\_\_ Home Answering Machine

\_\_\_\_\_ Work Voicemail or Answering Machine

\_\_\_\_\_ Cellular Phone Voicemail

\_\_\_\_\_ Email or Patient Web Portal

By signing this HIPAA disclaimer, it allows our office to release and/or obtain the Patient's medical information to and/or from insurance, medical doctors and to whom you list above. The Patient agrees that Three Rivers Medical Clinic may disclose information contained in the Patient's medical records.

At all times, the Patient retains the right to revoke this consent. Such revocation must be submitted to the Three Rivers Medical Clinic in writing.

\_\_\_\_\_  
Signature or Patient or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Authorized Representative

### Three Rivers Medical Clinic

PO Box 1078, 16 Railway Avenue, Three Forks, Montana 59752

Phone: (406) 285-3251 • Fax: (406) 285-6742

contact@threeriversmedicalclinic.net

Kristin M. Johnson, MSN, APRN, ANP-BC, FNP-BC • Jennifer K. Sofie, DNP, APRN, ANP-BC, FNP-C  
Cynthia A. Bates, MSN, APRN, FNP-BC • Sarah H. Sentz, MSN, APRN, FNP-C