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
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Phone: (406) 285-3251 ● **Fax:** (406) 285-6742
contact@threeriversmedicalclinic.net

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