Premier Care Pediatrics
Where your family comes first

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AUTHORIZATION FOR RELEASE OF INFORMATION

Full Name of Patient_____ DOB_____
Address: _____Phone_____ Date needed: _____ Mail ____Fax ____Pick up ____

I hereby authorize (facility/ provider):_____
Address: _____ Phone: _____Fax:_____

To release information to (facility/provider/other): _____
Address: _____ Phone: _____ Fax: _____

Purpose of disclosure: _____
Information Requested:

_____ Progress Notes
_____ Lab
_____ X-Ray
_____ All Records
_____ Immunizations
_____ Hospital
_____ Special Studies

Other: _____

ALL HEALTH CARE INFORMATION, WHETHER ORAL OR RECORDED IN ANY FORM OR MEDIUM, THAT IDENTIFIES THE PATIENT OR CAN READILY BE ASSOCIATED WITH THE PATIENT AND RELEASE TO THE PATIENT'S CARE, THIS WILL INCLUDE ALL HEALTH CARE INFORMATION IN YOU POSSESSION, WHETHER GENERATED BY M.D. OR ANY OTHER SOURCE, ALSO INCLUDED WILL BE HEALTH CARE INFORMATION ASSOCIATED WITH DRUG AND ALCOHOL USE, MENTAL OR PSYCHIATRIC CARE AND HIV STATUS OR DIAGNOSIS OF AIDS, OR OTHER SEXUALLY TRANSMITTED DISEASES. THE AUTHORIZATION SHALL BE VALID FOR ONE (1) YEAR FROM THE DATE RECORDED ON THE AUTHORIZATION UNLESS REVOKED TO THE SHORTER PERIOD OF TIME STATED HERE _____ AN UPDATED SIGNATURE FORM IS NEEDED EVERY YEAR.
THIS RELEASE IS SUBJECT TO REVOCATION AT ANY TIME. IF REVOKED, THE RELEASE TERMINATES IN ACCORDANCE WITH MONTANA STATE STATUTE 50-16-527. THE UNDERSIGNED UNDERSTANDS THAT THIS AUTHORIZATION MAY BE REVOKED AT ANY TIME, UPON WRITTEN NOTIFICATION FROM PREMIER CARE PEDIATRICS, EXCEPT TO THE EXTENT THAT PREMIER CARE PEDIATRICS, WHO IS TO MAKE THE DISCLOSURE. HAS ALREADY TAKEN ACTION IN RELIANCE.

Parent/Guarantor Signature: _____ Date: _____

Parent/Guarantor Printed Name: _____

Relationship to Patient: _____