

**Authorization to Disclose Protected Health Information**  
**Smile Montana Urgent Dental Center**

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Information to be released **FROM:**

Disclosure Method:

Smile Montana Urgent Dental Center  
115 Commons Way  
Kalispell, MT 59901

☐ Pick Up    ☐ Mail    ☐ Fax \_\_\_\_\_  
Email \_\_\_\_\_  
Other \_\_\_\_\_

This information may be given to and used by the following individual or organization. I hereby request and authorize you to release information **TO:**

Clinic or Dr's Name: \_\_\_\_\_  
Address: \_\_\_\_\_

I authorized the use or disclosure of the above named individual's health information as described below.

Information to be released:

- ☐ All Records of Treatment from \_\_\_\_\_ to \_\_\_\_\_
- ☐ Entire (Complete Record)    ☐ Medication Record    ☐ Allergy List
- ☐ Complete X-Rays    ☐ Financial Information

- I understand that the above-listed items or information in this clinic's possession may have been generated by this clinic or another source and will be released to the above listed clinic or individual.
- I understand there may be a fee for copying records that will need to be paid prior to receiving my health record.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in the Federal Privacy Regulations. If I have questions, I can contact this Clinic's Privacy/Security Officer.
- Unless otherwise revoked, this authorization will expire on the following date, event or condition:  
\_\_\_\_\_ (maximum of 30 months). If I fail to specify an expiration date, event or condition, this authorization will expire in 6 months in accordance with MCA 50-16-527.
- I understand that I may revoke this authorization in writing at any time by contacting the Clinics Privacy Officer.
- I certify that I have received a signed copy of this authorization.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
If Signed by Legal Representative, Relationship to Patient

\_\_\_\_\_  
Signature of Witness

**For Office Use Only**

Copied by: \_\_\_\_\_

**Payment**

**Amount:** \_\_\_\_\_

**Type:** \_\_\_\_\_

**Check #** \_\_\_\_\_