Authorization to Disclose Protected Health Information
Smile Montana Dental Center

Date: _____ Patient Name: _____
Date of Birth: _____ SSN: _____

Information to be released **TO**:

Smile Montana Dental Center 105 Nucleus Avenue Columbia Falls, MT 59912	Disclosure Method: ◯ 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 **FROM:**

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 #** _____