the golgi clinic, LLC

113 West Front Street, Suite 201
Missoula, Montana 59802
T 406-541-8886
www.thegolgiclinic.com
info@thegolgiclinic.com

Request & Authorization to Release Confidential Medical Information

From: _____ _____ _____
Physician/Clinic *Phone* *Fax*

To: _____ _____ _____
Physician/Clinic *Phone* *Fax*

For:

_____ _____ _____
Patient Name *Date of Birth* *Social Security Number*

_____ _____
Address *Apt.* *City/State/Zip*

☐ Health records (inclusive of: history, physical exams, surgical reports, vaccination logs)
☐ Lab results ☐ Imaging (X-ray, CT, MRI, US) and Reports
☐ Other _____

For the Following Periods:

☐ Previous month ☐ Previous ___ months ☐ Since first office visit

The Following Must be Initialed to be Included:

☐ HIV/AIDS related records ☐ Genetic testing
☐ Mental health visit records ☐ Drug/Alcohol abuse treatment

By signing below I agree to release of the aforementioned health information. I understand that I may refuse to sign this authorization, and my refusal to sign will not affect my ability to obtain health care services or reimbursement for services. The only circumstance where refusal to sign means I will not receive health care services, is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan. I understand that I many revoke this authorization in writing at any time, to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. Unless revoked earlier, this authorization will expire 6 months from the date of signing. ***There may be fees for providing copies.***

_____ _____
Signature of Patient/Authorized Representative Date