Authorization for Release of Individually Identifiable Health Information to Designated Party **Patient Last Name** First Name MI **Date of Birth Social Security Number** This authorization grants permission to the designated party (ies) named below to all of the following: Make or confirm appointments Verbal access to x-ray, laboratory, test findings, diagnosis, prognosis and treatment plans by telephone or other common means of communication Pick up sample medications Access to my financial health information I hereby authorize Missoula Surgical Associates to use and disclose my individually identifiable health information as described above. The following lists of people are the people I have designated to receive my individually identifiable health information. I understand that this authorization is voluntary. I understand that once this information is disclosed to the designated party (ies) named below, the release of information may no longer be protected by federal privacy regulations. I understand an authorization for release of information will need to be signed if a photocopy of my medical record is required. PLEASE PRINT THE INFORMATION BELOW: Address **Telephone** Name Relationship I understand that this authorization will be effective for the lifetime of the patient unless revoked in writing OR expires on_ I understand that I may revoke this authorization at any time by notifying the Medical Records Department in writing; however, the revocation will have no effect on disclosures made prior to the receipt of the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization. I authorize messages to be left on my phone regarding my protected health information. ☐ Yes \square No As a service to our patients, we provide a courtesy appointment reminder call/text and possibly other important calls/texts that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls/texts at this number. □ Yes □ No Place Label Here Signature of Patient Date Printed Name of Patient's Legal Representative Relationship Signature of Patient's Legal Representative Date