Pt Name: _____ MRN: _____
Pt DOB: _____ Phone Number: _____

CENTRAL MONTANA MEDICAL CENTER

PLEASE FILL OUT COMPLETELY

Please complete this form if you wish to grant a representative the ability to communicate with us about you and your health.

Completing this form will enable the person(s) of choice to gain access to talk to us about your care and give and receive information about you. This form does not allow permissions for release of medical records.

1. **I authorize Central Montana Medical Center to discuss my medical information with the following individuals:**

   Individual's Name _____ Phone number_____ Relationship _____

   Individual's Name _____ Phone number _____ Relationship _____

   Individual's Name _____ Phone number _____ Relationship _____

   ☐ Do not release any medical information to anyone.

2. **What can be shared verbally with this person(s):**
   ☐ Questions about my medication or prescription requests.
   ☐ Details of my appointments – e.g., times and dates, to be able to cancel appointments and make appointments when necessary.
   ☐ Any referrals that have been made on my behalf.
   ☐ My medical care and test results.
   ☐ My billing and insurance information.
   ☐ All of the above
   ☐ Excludes: _____

3. **What are some examples of when this form might be useful?**
   - If an elderly parent wants an adult child to help understand medical treatment instructions.
   - If an adult child is helping with billing questions.
   - If a friend is helping an elderly patient with health issues.
   - If a family member is requesting for schedule date and time for appointment.
   - If a college student wants information shared with a parent.
   - If an adult child calls to find out his/her patients appointment time.

Patient / Authorized Representative Signature: _____ Date / Time: _____

Printed Name of Authorized Representative: _____

☐ Patient unable to sign due to condition.

Witness Signature: _____ Date/ Time: _____

Staff Username: _____ Date / Time: _____