BELLAMAH
VEIN CENTER

Authorization for Release of Individually Identifiable Health Information to Designated Party

_____	_____	___	_____
Patient Last Name	**First Name**	**MI**	**Date of Birth**

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 Bellamah Vein Center 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:

_____	_____
Name/Relation	Name/Relation

I understand that this authorization will be effective for the lifetime of the patient unless revoked in writing ***OR*** expire 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 do, ☐ I do NOT, give permission to leave detailed messages on my voicemail regarding: appointments, procedure instructions, test results, billing and/or insurance issues or other pertinent information from Bellamah Vein Center.

_____	_____
Signature of Patient	Date
_____	_____
Signature of Patient's Legal Representative/Relationship	Date

David H. Bellamah, M.D., FACS
Bellamah Vein Center, PLLC
2975 Stockyard Road; Suite 200 ◦ Missoula, MT 59808
575 Sunset Blvd.; Suite 104 ◦ Kalispell, MT 59901
Phone: 406.541.3200 ◦ Fax: 406.541.3201