Pt Name: _____

MRN: _____

Pt DOB: _____

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 tot talk to us about your care and give and receive information about you.

1. **Patient Information**
   Legal name of patient _____

   Date of Birth _____ Phone number _____

   Please provide email address if you would like to access your patient portal_____
2. **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 _____

3. **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 medical records
   ☐ Excludes: _____

4. **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/Legal Representative Printed Name Date Time Patient / Legal Representative Signature