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.

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☐ 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.

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| _____ | _____ |
|---|---|
| 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**