GISLASON
FAMILY
CHIROPRACTIC
Dr. Eric J. Gislason, D.C.

H.I.P.A.A.
Authorization For Release of Medical Information
Claim # _____

I hereby authorize: Gislason Family Chiropractic/GFC, Inc.
5875 Hwy 93 South, Suite A
Whitefish, Montana 59937 (406) 862-9700

To release to: _____
_____
_____

Medical Records for: _____ (Patient Name)
Obtained during _____ (Address)
the course of _____ (City/ST/Zip)
Treatment. _____ (Social Sec. #)

Pursuant to Section 27-12-302(2), Montana Codes Annotated, the undersigned hereby authorizes the Montana Chiropractic Legal Panel to obtain access to all claims for treatment, medical and hospital records and information pertaining to the claim. I understand that this Authorization extends to all or any part of the records/information which may include treatment for physical and metal illness, alcohol/durum abuse, sexually transmitted diseases and HIV/AIDS test results or diagnoses. I Authorize the above named person/entity to deliver any and all such information or copies thereof to the Director of the Montana Chiropractic legal panel, or authorized agent(s).

The treatment dates covered by this Authorization include all dates of treatment. The undersigned waives any privilege as to the contents of those records for the purposes of consideration by the Montana Chiropractic Legal Panel only, which includes distribution of the records to the chiropractic physicians named in the claim before the Panel, or their attorneys and the members of the Panel sitting in hearing on the above claim. Nothing in this statement shall in any way be construed as waiving that privilege for any other purpose or in any other context, in or out of court.

In any event, I may revoke this Authorization at any time, except to the extent that action has been taken in reliance thereon. Authorization will automatically expire 120 days from the date claim received by the Montana Chiropractic Legal Panel. I hereby release the Montana Chiropractic Legal Panel from all legal responsibilities or liability that may arise from disclosure of medical records in reliance on this Authorization. (If patient is a minor, both the patient and a parent or legal guardian must sign this Authorization.)

_____ _____ _____
Date Patient's Signature Patient's Printed Name

_____ _____
Date Witness Signature

_____ _____
Date Parent / Legal Guardian Signature