

1220 Central Avenue, Great Falls, Montana 59401 l Telephone: 406-268-1510

Notice of Disclosure of Information

Assignment of Benefits and Release of Information

This form allows Indian Family Health Clinic of Great Falls, Inc. (IFHC) to bill your insurance and provide your medical treatment, products, supplies, and/or services rendered by IFHC.

Your signature on the line below authorizes the following:

I request payment of authorized Medicare, Medicaid, Private Insurance, or other forms of coverage be made on my behalf directly to IFHC for any medical treatment, products, supplies, or services rendered by IFHC. I hereby authorize any holder of medical information about me to release to my insurance carrier or any agency or representative of insurance company for obtaining payment for services provided to me. I also authorize the review of my records including medical records by authorized Federal, State, or accrediting body of agency as required by the regulatory, licensing or accrediting body. I will allow IFHC to obtain any information necessary in order to process my claim(s) and to contact me by telephone or mail regarding my medical treatment, products, supplies or services or related medical information.

Patient’s or Authorized Person’s Consent

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient if signed by another party:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Confidential

IFHC Health Clinic Form FY 2023