HIGHLINE DERMATOLOGY & SKIN CANCER

Authorization to Disclose Protected Health Information

Patient Information	Name: ______________ Date of Birth: ______________ Address: ______________ Phone: ______________ City: ______________ State: __________ Zip: __________
Hospital/Clinic/ Health Care Provider (Who has the information you want released? Please list the specific hospital and/or clinic.)	Facility Name: ______________ Phone: ______________ Fax: ______________ Facility Name: ______________ Phone: ______________ Fax: ______________
Receiving Party (Where do you want the information sent? Who may have the information?)	Name: ______________ Address: ______________ Phone: ______________ City: ______________ State: _____ Zip: ________ Fax #: ______________
Information to be Released (What do you want sent or released? Check the appropriate box.)	Date range of information to be released: From: ______________ (Month/Year) To: ______________ (Month/Year) **Please check specific information to be released:** ☐ Entire Record ☐ Discharge Summary/Note ☐ History and Physical ☐ Consultation Report ☐ Operative Report ☐ Progress Notes ☐ Emergency Record(s) ☐ Pathology Reports ☐ Laboratory Reports ☐ Medication List ☐ Billing ☐ Other ______________
Release Instructions (How and when do you want the information?)	Date information is needed: ______________ Disclosure Method: ☐Pickup ☐Mail ☐CD ☐Fax # ______________ ☐ Other ______________ **Note:** *Fees may be charged in accordance with Federal and State law.

By signing this authorization form, I understand that:

- The information in the health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) and genetic information. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. However, this authorization does not apply to psychotherapy notes.
- Once the information described herein is disclosed; it could be re-disclosed by the recipient and may not be protected by privacy protections.
- I have the right to revoke this Authorization at any time. Revocation must be in writing and presented to medical records at fax number 406-890-6708. Revocation will not apply to information that has already been disclosed in response to this Authorization.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Requests for copies of health records are subject to reproduction fees in accordance with Federal and State law.
- I can receive a copy of this Authorization and that it will become a part of my medical record.
- Unless otherwise revoked, this Authorization will expire on the following date/event/condition: ______________.

If I fail to specify an expiration date/event/condition, this Authorization will expire six (6) months from the date it is signed.

____
Signature of Patient or Legal Representative   Printed Name   Date

______________   ______________
If Signed by Legal Representative, Relationship to Patient   Signature of Witness   Printed Name

Revocation Authorization	*I hereby revoke (cancel) this Authorization to Disclose Protected Health Information.* *Cancellation Signature:* ______________ *Date:* ______________