



Authorization to Disclose Protected Health Information

<p>Patient Information</p>	<p>Name: _____ Date of Birth: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____</p>														
<p>Hospital/Clinic/ Health Care Provider (Who has the information you want released? Please list the specific hospital and/or clinic.)</p>	<p>Facility Name: <u>Dermatology Associates</u> Phone: (406) 756-7555 Fax: (406) 756-7517 Address: 175 Commons Loop, Suite 300 Kalispell MT 59901</p>														
<p>Receiving Party (Where do you want the information sent? Who may have the information?)</p>	<p>Name: <u>Highline Dermatology & Skin Cancer</u> Address: <u>40 Four Mile Drive, Suite 7</u> Phone: <u>(406) 314-4788</u> City: <u>Kalispell</u> State: <u>MT</u> Zip: <u>59901</u> Fax #: <u>(406) 890-6708</u></p>														
<p>Information to be Released (What do you want sent or released? Check the appropriate box.)</p>	<p>Date range of information to be released: From: _____ To: _____ (Month/Year) (Month/Year)</p> <p>Please check specific information to be released:</p> <table border="0"> <tr> <td><input type="checkbox"/> Entire Record</td> <td><input type="checkbox"/> History and Physical</td> </tr> <tr> <td><input type="checkbox"/> Discharge Summary/Note</td> <td><input type="checkbox"/> Operative Report</td> </tr> <tr> <td><input type="checkbox"/> Consultation Report</td> <td><input type="checkbox"/> Emergency Record(s)</td> </tr> <tr> <td><input type="checkbox"/> Progress Notes</td> <td><input type="checkbox"/> Laboratory Reports</td> </tr> <tr> <td><input type="checkbox"/> Pathology Reports</td> <td><input type="checkbox"/> Billing</td> </tr> <tr> <td><input type="checkbox"/> Medication List</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>	<input type="checkbox"/> Entire Record	<input type="checkbox"/> History and Physical	<input type="checkbox"/> Discharge Summary/Note	<input type="checkbox"/> Operative Report	<input type="checkbox"/> Consultation Report	<input type="checkbox"/> Emergency Record(s)	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Billing	<input type="checkbox"/> Medication List		<input type="checkbox"/> Other _____	
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<p>Release Instructions (How and when do you want the information?)</p>	<p>Date information is needed: _____ Disclosure Method: <input type="checkbox"/> Pickup <input type="checkbox"/> Mail <input type="checkbox"/> CD <input type="checkbox"/> Fax # _____ <input type="checkbox"/> Other _____ Note: *Fees may be charged in accordance with Federal and State law.</p>														
<p>By signing this authorization form, I understand that:</p> <ul style="list-style-type: none"> •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: _____. <p>If I fail to specify an expiration date/event/condition, this Authorization will expire six (6) months from the date it is signed.</p>															
<table border="0"> <tr> <td>Signature of Patient or Legal Representative _____</td> <td>Printed Name _____</td> <td>Date _____</td> </tr> <tr> <td>Signed by Legal Representative, Relationship to Patient _____</td> <td>Signature of Witness _____</td> <td>Printed Name _____</td> </tr> </table>		Signature of Patient or Legal Representative _____	Printed Name _____	Date _____	Signed by Legal Representative, Relationship to Patient _____	Signature of Witness _____	Printed Name _____								
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<p>Revocation Authorization</p>	<p><i>I hereby revoke (cancel) this Authorization to Disclose Protected Health Information.</i></p> <p>Cancellation Signature: _____ Date: _____</p>														