AUTHORIZATION TO RELEASE MEDICAL RECORDS

Printed Name of Patient:		Birthdate:
Address:	City, State:	Zip Code:
Phone Number:	Only if applicable: Parent/Legal Agent Signing Release:	

I hereby authorize the following health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer, or family member to release all health information about me:

Person/Organization to Release Information:		
Address:	City, State:	Zip Code:
Phone Number:	Fax Number:	

The following person/organization is hereby authorized to receive my entire medical record, treatment record and diagnostic record:

Person/Organization to Receive Information: Montana Sky Dermatology, PC		
Address: 1600 Whitefish Stage Road, Suite 1	City, State: Kalispell, MT	Zip Code: 59901
Phone Number: (406) 314-4477	Fax Number: (406) 558-2844	

Dates of Service to be Released: From: _____ To: _____ or ❑ All Dates

Information to be Released: ❑ Complete Medical Record ❑ Other: _____
I understand that my record may include one or more of the following: Mental Health – Alcohol & Drug Abuse/Treatment – Sexually Transmitted Disease (STD) Diagnosis/Treatment – HIV Diagnosis/Treatment – Genetic Testing

Purpose for which information is being released:

- ❑ Permanent Transfer to Another Provider
- ❑ Consultation with Specialist
- ❑ Insurance
- ❑ Inspect records on site
- ❑ Continued Medical Care
- ❑ Personal Use
- ❑ Legal
- ❑ Other_____

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law. This authorization is valid for 24 months following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

Patient/Parent/Legal Agent Signature:	Date Signed: