610 N California St ·Missoula, MT 59802
(406)721-1646 · 800-727-2546 · FAX (406)543-9890
www.bluemountainclinic.org

Authorization for Release of Information

Patient Name_____
Last First Middle Other Name

Date of Birth____/____/____ SS#_____/_____/_____ Phone_____
Address_____City_____State____Zip_____

OR

☐ I authorize Blue Mountain Clinic **to release information to** the following provider:

_____
Name of provider or facility

_____
Address

_____
City, State, Zip code

_____
Phone number, fax number (include area code)

☐ I authorize Blue Mountain Clinic **to obtain information from** / I authorize this provider to release information to Blue Mountain Clinic:

_____
Name of provider or facility

_____
Address

_____
City, State, Zip code

_____
Phone number, fax number (include area code)

OR ☐ **I am requesting a copy of my records for my own use.**
Please _____Fax _____Mail _____Contact me to pick up records from the clinic

Information to be released:

___Progress (Visit) Notes
___Lab Reports
___X-Ray Reports
___All Records
__Other (please describe): _____
__Records relating to a specific illness or injury:
_____ dates: _____
(specify illness or injury)

Please specify the reason for disclosure:

___Changing Physicians ___Consultation/Second Opinion ___Continuing Care
___Legal ___School ___Insurance
___Other (please specify)_____

1. I understand that this authorization will expire 180 days after I have signed this form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that if I am being requested to release this information by my provider, my health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I have signed it.

Signature of Patient (or representative)_____Date_____

If representative, relationship to patient (i.e. parent, guardian, etc.) _____