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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:	☐ 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	*Name of provider or facility*
Address	*Address*
City, State, Zip code	*City, State, Zip code*
Phone number, fax number (include area code)	*Phone number, fax number (include area code)*

OR ☐ **I am requesting a copy of my records for my own use via: _____Fax____Mail___Paper pickup _____ Email***

*Email address _____

*Password for encrypted pdf(must contain numbers, letters, and one uppercase letter): _____

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 365 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 uponit.
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 may request a copy of this form once signed.

Signature of Patient (or representative)_____Date_____

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