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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:

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 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
____ Legal
____ Other (please specify) _____
____ Consultation/Second Opinion
____ School
____ Continuing Care
____ Insurance

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 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 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.) _____