Blue Mountain Clinic
FAMILY PRACTICE
610 N California St, Missoula, MT 59802
PHONE (406) 721-1646 or (800) 727-2546
FAX (406) 543-9890 **www.bluemountainclinic.org**

Medical Records Release

Legal Name _____ Birth Date: _____ / _____ / _____
(first) (last) (middle initial)

Other Name _____ SSN : _____ - _____ - _____

Adress: _____ City _____ State _____ Zip _____

I hereby authorize the use or disclosure of my individually identifiable health information as described below

Check all that apply:

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

☐ I authorize Blue Mountain Clinic to **obtain information from** the following provider, thereby authorizing the following provider to release information to Blue Mountain Clinic:

_____ _____
Name of provider or facility *phone/fax number (include area code)*

_____ _____ _____ _____
Provider address *City* *State* *Zip*

☐ **Request copy of medical records for personal use via:** ☐ Mail ☐ Pick Up ☐ Fax Number _____

☐ Email *(will be sent as an encrypted pdf and requires a password containing numbers, letters, and one uppercase letter)*

Email address _____ Password _____

Information to be released:

- ☐ Progress/Visit Notes
- ☐ Lab Reports
- ☐ X-Ray Reports
- ☐ All Records
- ☐ Other *(please specify):* _____
- ☐ Records relating to a specific illness or injury:

_____ _____
(please specify illness/injury) *(please specify dates)*

Specify Reason for Disclosure:

- ☐ Changing Physicians
- ☐ Consultation
- ☐ Continuing Care
- ☐ Legal
- ☐ School
- ☐ Insurance
- ☐ Other *(please specify):* _____

I have read and understood the following statements about my rights:

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 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: _____

Relationship to patient *(i.e. parent, guardian, etc.)* _____