Records Release

B·I·L·L·I·N·G·S Dermatology & Aesthetics

Patient Authorization for Use & Disclosure of Protected Health Information

PT Name:_____ **DOB:** _____

Address: _____

Telephone: _____

By signing this authorization, I authorize the following; :_____

Address/Phone/Fax:_____

To release my medical records to Name: **Billings Dermatology PC** _____

Address/Phone/Fax: 2294 Grant Road, Billings, Mt. 59102 / **P:** 406-294-9515 / **F:** 406-294-9520

This authorization permits the above mentioned to use and/or disclose the following individual health information about me (specifically describe the information to be used or disclosed):

- Complete health record(s)
- Progress notes
- Consultation reports
- Pathology
- Other (please specify)_____

From (date): _____ to _____

Unless otherwise cancelled, this authorization will expire 12 months.

I DO NOT HAVE TO SIGN THIS AUTHORIZATION IN ORDER TO RECEIVE TREATMENT FROM BILLINGS DERMATOLOGY PC

In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to Billings Dermatology PC, 2294 Grant Rd, Billings, MT 59102

_____ _____

Print Name of Patient Signature of Patient or Guardian

_____ _____

Print Name of Guardian Relationship to Patient

_____

Date