# Records Release

**Patient Authorization for Use and Disclosure of Protected Health Information**

Patient Name: _____Date of Birth: _____

Mailing Address: _____ City: _____ State: _____ Zip:_____

Home Phone: (  ) _____ Mobile Phone: (  ) _____

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By signing this authorization, I authorize the following: _____

Address _____Phone _____Fax _____

To release my records to: Name _____

Address _____Phone _____Fax _____

**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) _____

Phone _____ Fax _____

*Unless otherwise cancelled, this authorization will expire 12 months.*

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## 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 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

_____ _____Date_____/_____/_____

Print Name of Patient  Signature of Patient or Guardian

_____ _____Date_____/_____/_____

Signature of Guardian  Relationship to Patient