SKIN CARE MT

AUTHORIZATION FOR RELEASE AND RECEIPT OF PROTECTED HEALTH INFORMATION (PHI) PURSUANT TO HIPAA

Skin Care MT is hereby authorized to receive from or disclose to the entity listed below confidential protected health information (PHI) about me, by receiving or releasing a copy of my medical records, or a summary or narrative of my PHI, from or to the person(s) or entity listed below.

☐ Mail PHI to:
☐ Fax PHI to:
☐ Receive PHI from:
☐ Release PHI to be picked up by:
☐ Discuss PHI with

(Check only one of the above)

Please circle one below: **Please circle one below:**
Discuss / release / receive my protected health information **with / to / from** the following person(s)/entity:

Name:	
Address City State Zip	
Phone #	Fax #

The following individually identifiable health information:
☐ All Records ☐ Chart Notes ☐ Labs ☐ Pathology Reports ☐ OTHER:

Purpose of Disclosure:
☐ Personal Records ☐ Continuation of Care ☐ Transfer of Care ☐ Insurance Application ☐ OTHER:

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. 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 acknowledge the right to revoke this authorization in writing. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. My written revocation must be submitted to Skin Care MT at 1905 West College, Bozeman, MT 59718. I understand that authorizing the disclosure of this health information is voluntary. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I also understand that I get a copy of this form after I sign it.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

☐ 3 months ☐ 6 months ☐ One year ☐ Fulfillment of this request ☐ OTHER: _____

Patient's Name:	Date of Birth
Signature of Patient or Legal Guardian	Date
Print Name of Patient or Legal Guardian	Relationship to Patient