PO Box 11141
Kalispell, MT 59904
Office (406) 314-7807

Two-Way Authorization to Release Confidential Health Information

In accordance with Federal and State statutory requirements concerning confidentiality of records, I request and give my permission to release/exchange information regarding the following individual:

Patient Name: _____ Date of Birth: _____

(Please Print)

I hereby authorize the following medical information to be released between:

_____

_____ AND Montana Dermatology

_____ PO Box 11141

_____ Kalispell, MT 59904

The specific health information to be released/exchanged is:

_____Pathology Records
_____Laboratory Records
_____Most Recent Progress Note
_____Partial Medical Record _____
_____Complete Medical Record
_____Other _____

Integrity Dermatology wants you to be aware of the potential that this information, once forwarded to the other party, could be re-disclosed and no longer protected.

This requested information is to be used for the purpose of _____.
I understand that this consent may be revoked at any time by requesting a Revocation of Two-Way Authorization form. In any event, if not previously revoked, this consent will expire on _____ or one year from the signature date.

Signature of Patient: _____ Date: _____

Signature of Personal Representative: _____ Date: _____

Signature of Witness: _____ Date: _____

NOTE: A photocopy or fax of this signed release form is as valid as the original.