



RELEASE OF MEDICAL RECORDS AUTHORIZATION FORM

Patient Information

Name _____

**Date
of
Birth** _____

**Phone
Number:** _____

Address _____

City _____ **State** _____ **ZIP** _____

Recipient of Records

I hereby authorize the release of my medical records **TO:**

Name/Organization Benjamin Lawson / Montana Kidney

Address 3550 Mullin Rd, Suite 103A

City Missoula **State** MT **ZIP** 59808

Phone 406-213-8939 **Fax** 406-224-6127

Information To Be Released

I authorize the release of the following medical Information (check all that apply):

- Complete Medical Record
- Lab Reports
- Imaging/Radiology Reports
- Mental Health Records*
- HIV/AIDS Testing Records
- Drug/Alcohol Treatment Records*
- Other (Please specify) _____

** May require additional authorization or comply with federal/state-specific confidentiality laws.*

Purpose of Disclosure

I authorize the release of the following medical Information (check all that apply):

- ____ Continuation of Care
 - ____ Legal
 - ____ Insurance
 - ____ Personal Use
 - ____ Other (Please specify)
-

Patient Rights & Acknowledgement

- I understand that I may revoke this authorization at any time in writing
 - I understand that revocation does not apply to information already released
 - I understand that information disclosed under this authorization may be subject to re-disclosure and my no longer be protected by HIPAA privacy regulations
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CONSENT FOR RELEASE OF MEDICAL INFORMATION

This consent permits the Practice to use and disclose my protected health information to carry out treatment, payment, or healthcare operations. Additional information regarding the uses and disclosures of protected health information is described in the Practice's notice of privacy practices. A patient has the right to review the 'notice' prior to signing this consent. A patient has the right to request restrictions, uses, and disclosures of health information for treatment, payment, and healthcare operations purposes. However, the Practice is not required to agree to a patient's request for restrictions. I may revoke this consent to release confidential information in writing at any time, except to the extent that action has already been taken. No further confidential information is released without the execution of an additional written statement of authorization. I understand that these records are protected under federal and state law and cannot be disclosed without my consent unless otherwise provided by law. Having read the above information, I hereby RELEASE, HOLD HARMLESS, AND AGREE NOT TO SUE the Practice, its employees, staff, and agents, in connection with the disclosure of information set forth relating to these medical records

Participation in the HIE helps ensure continuity of care by providing a more complete and timely view of your medical history, medications, test results, and treatment plans—regardless of where you receive care.

Signature _____

If signed by a personal representative:

Name _____

Relationship to Patient _____

Legal Authority: POA Legal or Guardian/Parent or Other (Please specify)