RiverStone Health Clinic
Authorization for Release of Protected Health Information

Full Name of Patient: ______________________________

Address: ______________________ City: ____________ State: __________ Zip: __________

Phone No.: ______________________ Date of Birth: ______________________

I authorize **RiverStone Health Clinic** to disclose the following protected health information ("my protected health information") for:
(check one) ☐ the previous 12 months (from date of signature below) ☐ from the time period beginning __________ and ending on __________.

(Please initial)

☐ Medical Summary ______________
☐ Progress Note(s) ______________
☐ Lab Results ______________
☐ Mental Health Information ______________
☐ Chemical Dependency ** ______________

(Please initial)

☐ X-Ray Reports ______________
☐ Consultations ______________
☐ Immunizations ______________
☐ AIDS/HIV ______________
☐ Other (Please Specify and Initial) ______________

☐ If this box is checked, RiverStone Health Clinic may discuss my protected health information with the individual or agency named below.

TO:

Name of Individual(s) or Agency: ______________________ Fax: ______________

Address: ______________________ City: ____________ State: __________ Zip: __________

I authorize the release of my protected health information for the following purpose(s):

☐ At the request of the individual ☐ Other (Please Specify) ______________________

By signing this authorization, I understand that I am authorizing RiverStone Health Clinic to use or disclose my protected health information for the purpose(s) I have identified. I understand I can revoke this Authorization in writing and doing so will stop future use or disclosure of my protected health information; but I understand that RiverStone Health Clinic can act on this Authorization until either I revoke my authority in writing or until the expiration date in this Authorization. If I want to revoke this Authorization, I will send my written notice of revocation to RiverStone Health Clinic as follows:

ATTN: Chief Privacy Officer
RiverStone Health Clinic
123 South 27th Street
Billings, MT 59101
Fax: 406.247.3389

I understand I can refuse to sign this Authorization and I am signing it of my own free will. I understand that should I decide to not sign this Authorization there will be no retaliation from RiverStone Health Clinic nor will there be any effect on my treatment or payment for services RiverStone Health Clinic provides, unless this authorization is required in order for me to participate in a research project or clinical trial, in which case I realize I may not be eligible for such project or clinical trial unless I authorize the use or disclosure of my protected health information. I understand I can see and copy my protected health information as described in RiverStone Health Clinic's Notice of Privacy Practices Policy. I understand RiverStone Health Clinic cannot control any further disclosure of my protected health information by those who receive it after it is disclosed as allowed by this Authorization, and that my protected health information may not be subject to continued protection under federal law once it is received by the recipient.

I understand that I will receive a copy of this Authorization after it is signed. Photocopies or faxed copies of this signed Authorization shall be treated as executed originals.

Unless I indicate an earlier time, this Authorization expires thirty (30) months from the date I sign______________________.
I also authorize the recipient of this Authorization to speak with me about the patient.

*Patient/or Legal Representative Signature: ______________________ Date: ______________

Explanation if Not Signed By patient: ______________________

*The signature must be that of PATIENT. A parent or guardian must sign if the patient is a minor (under 18) or under guardianship proceedings; (if signed by a guardian or under legal authority to act for the patient, or if this Authorization is signed by a personal representative of a deceased patient, proof of authority to act is required.)

**NOTICE TO WHOMEVER DISCLOSURE IS MADE: This information has been disclosed to you from records, the confidentiality of which is protected by Federal Law. Federal regulations (42 CRF Part 2) prohibit any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.