123 S. 27th Street
Billings, MT 59101
Phone: 406.247.3350 Fax: 406.247.3389

Office use only
Requesting Provider:
_____

Authorization for Request of Protected Health Information

Full Name of Patient: _____ Other Name/s:_____

Address: _____City: _____State:_____ Zip:_____

Phone No: _____ Date of Birth: _____Social Security #: XXX - XX-_____
(Last 4 digits)

Requesting Records From:

I authorize: _____ Fax: _____
Name of Individual(s) or Agency)

Phone: _____

Address:_____City:_____ State:_____ Zip:_____

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)		(Please Initial)	
_____	History Summary **(1 page summary)** _____	_____	Mental Health Information**_____
_____	Progress Notes_____	_____	Chemical Dependency**_____
_____	Lab Results/Pathology_____	_____	Colonoscopy reports _____
_____	X-Ray reports _____	_____	Pap & mammogram reports_____
_____	Consultations_____	_____	Immunizations_____
_____	AIDS/HIV Testing _____	_____	Other (Specify)_____

_____ If this is checked, the individual or agency named above may discuss my protected health care information.

to **RiverStone Health Clinic**, for the following purpose(s):

☐ At the request of the individual ☐ Other (Specify)_____

By signing this authorization, I understand that I am authorizing the Provider to use or disclose my protected health information to RiverStone Health Clinic 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 Provider 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 Provider.

I understand I can refuse to sign this Authorization and I am signing it of my own free will. I understand that if I should decide to not sign this Authorization there will be no retaliation from Provider nor will there be any effect on my treatment or payment for services Provider 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 Provider's Notice of Privacy Practices Policy. I understand Provider cannot control any further disclosure of my protected health information by those who received 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.

Unless I indicate at an earlier time, this Authorization expires twenty-four (24) months from the date I sign:_____.

***Patient Signature**: _____ **Date:** _____

Explanation if not signed by patient: _____

Witness: _____ Date: _____

*This signature must be that of the 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, 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.