# 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 Clinic** to disclose the following protected health information ("my protected health information") from the time period beginning on _____ and ending on LAST 2 YEARS OF SPECIFIED CONDITION

| | (Please initial) | | (Please initial) |
|---|---|---|---|
| ☒ | Medical Summary | ☒ | X-Ray Reports |
| ☐ | Progress Note(s) | ☒ | Consultations |
| ☒ | Lab Results | ☐ | Immunizations |
| ☒ | Mental Health Information | ☒ | AIDS/HIV |
| ☐ | Chemical Dependency ** | ☐ | Other (Please Specify and Initial) |

TO: Dr. Michael Uphues, DO Caduceus Medical Partners, LLC Fax: 406-969-2447

Name of Individual(s) or Agency

Address: 724 Grand Avenue, City: Billings, State: MT Zip: 59101

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

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

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

By signing this authorization, I understand that I am authorizing RiverStone 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 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 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 Clinic nor will there by any effect on my treatment or payment for services RiverStone 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 Clinic's Notice of Privacy Practices Policy. I understand RiverStone 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 _____.

*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 an 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.