

YELLOWSTONE NATUROPATHIC CLINIC

720 North 30th Street – Billings Montana 59101

Office 406-259-5096 Facsimile 406-294-7783

**AUTHORIZATION FOR RELEASE OF INFORMATION
TO YELLOWSTONE NATUROPATHIC CLINIC**

Patient Name: _____ Date of Birth: _____

I hereby authorize the release of my records **FROM:** _____

- St. Vincent Hosp Billings Clinic Other _____

TO release my personal health and medical information as described below to the following person(s) or health care provider(s):

- Dr. Margaret Beeson, ND Dr. Deborah Angersbach, ND
- Dr. Patricia Holl, DC Dr. Krista Brayko, ND Dr. Christine Stubbe, ND

Information to be disclosed:

- complete health record(s) films consultation reports
- ALL laboratory tests information progress notes other: _____
- radiology reports discharge summary _____

From (date) _____ To (date) _____
 From (date) _____ To (date) _____

I understand that this will include information relating to (check if applicable):

- Acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV).
- Behavioral health services/psychiatric care.

What is the purpose or use of the disclosure? _____

The patient or the patient’s representative MUST read and initial the following statements:

I understand that this authorization is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

Initial: _____

I understand that I may inspect or receive a copy of the information described on this form if I ask for it and that I will receive a copy of this form after I sign it.

Initial: _____

Unless otherwise cancelled, I understand that this authorization will expire after 12 months or on the following date, event or condition: _____.

Initial: _____

I understand that I may cancel this authorization at any time by notifying the providing health care provider in writing, but if I do, it won’t have any effect on actions taken prior to receipt of the cancellation.

Initial: _____

I understand that if the person or entity that receives the above information is not a health care provider or a health plan provider covered by federal privacy regulations, the released information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. The recipient may otherwise be prohibited under federal law from redisclosing substance abuse information, AIDS/HIV status or mental health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Initial: _____

_____ Date: _____

(signature/name of patient and/or patient representative)

If signed by **other** than patient, indicate relationship: _____

Signature of Physician: _____ **Witness:** _____ **Date:** _____