YELLOWSTONE NATUROPATHIC CLINIC

720 North 30th Street – Billings Montana 59101
Office: 406-259-5096 Fax: 406-545-0044

AUTHORIZATION FOR RELEASE OF INFORMATION TO YELLOWSTONE NATUROPATHIC CLINIC

Patient Name: _____ Date of Birth: _____

I hereby authorize the release of my records FROM:

Doctor's Name:_____Specialty:_____

___St. Vincent ___Billings Clinic ___Other: (*include City& State*) _____

Any and/or all records _____

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. Patricia Holl, DC ____James Madison, L.Ac

____ Dr. Danielle Phillips-Dorsett, ND ____Dr. Kaila Sellars, ND ____ Dr. Ryan Turnewitsch, ND

____ Dr. Melissa Manda, ND ____ Dr. Chris Ballantine, ND ____Dr. Shelah Deans, ND

Information to be disclosed:

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:_____

Patient signature_____ Date:_____
(and/or patient representative)

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

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

***Doctor's Name: ____ Specialty:_________________________________

___ St. Vincent - ___ Billings Clinic - ___ Other (***include City & State***):____

Any and/or all records: ____

Dates: __________ to ____________

***Doctor's Name: ____ Specialty:_________________________________

___ St. Vincent - ___ Billings Clinic - ___ Other (***include City & State***):____

Any and/or all records: ____

Dates: __________ to ____________

***Doctor's Name: ____ Specialty:_________________________________

___ St. Vincent - ___ Billings Clinic - ___ Other (***include City & State***):____

Any and/or all records: ____

Dates: __________ to ____________

***Doctor's Name: ____ Specialty:_________________________________

___ St. Vincent - ___ Billings Clinic - ___ Other (***include City & State***):____

Any and/or all records: ____

Dates: __________ to ____________

***Doctor's Name: ____ Specialty:_________________________________

___ St. Vincent - ___ Billings Clinic - ___ Other (***include City & State***):____

Any and/or all records: ____

Dates: __________ to ____________

***Doctor's Name: ____ Specialty:_________________________________

___ St. Vincent - ___ Billings Clinic - ___ Other (***include City & State***):____

Any and/or all records: ____

Dates: __________ to ____________
