



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: _____

Additional records requests can be added to back page

St. Vincent Billings Clinic Other: (include City& State) _____

- | | | |
|---|---|---|
| <input type="checkbox"/> Pap | <input type="checkbox"/> XR _____ | <input type="checkbox"/> Office Notes _____ |
| <input type="checkbox"/> Mammogram | <input type="checkbox"/> MRI _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Labs _____ | <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cardiology Notes | <input type="checkbox"/> Physical Therapy Notes | |

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

- | | | |
|--|---|--|
| <input type="checkbox"/> Margaret Beeson, ND | <input type="checkbox"/> Samantha Pryor, ND | <input type="checkbox"/> Patricia Holl, DC |
| <input type="checkbox"/> Cameron Crow, ND, LAc | <input type="checkbox"/> Sierra Cortes, 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: _____

***Doctor's Name: _____ Specialty: _____ Dates: _____ to _____

___ St. Vincent ___ Billings Clinic ___ Other (include City & State): _____

- | | | |
|---|---|---|
| <input type="checkbox"/> Pap | <input type="checkbox"/> XR _____ | <input type="checkbox"/> Office Notes _____ |
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| <input type="checkbox"/> Labs _____ | <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cardiology Notes | <input type="checkbox"/> Physical Therapy Notes | |

Physician Signature: _____ Witness: _____ Date: _____