

RIMROCK FOUNDATION

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

1.1 **PATIENT NAME:** _____ Date of Birth _____

freely authorize Rimrock Foundation, 1231 North 29th Street, Billings, MT 59101, and the following named agencies and/or persons to use, disclose, discuss, and exchange with each other the information indicated below. (See #2)

(a) Agency/Name _____

Address _____ City _____ State _____ Zip _____

Home Phone: _____ Work: _____ Fax: _____ Cell: _____

(b) Agency/Name _____

Address _____ City _____ State _____ Zip _____

Home Phone: _____ Work: _____ Fax: _____ Cell: _____

2. The type and amount of information to be used or disclosed is as follows: (provide a specific and meaningful description of the information, including dates where appropriate)

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Psych/Social Assessment | <input type="checkbox"/> DUI Evaluation | <input type="checkbox"/> Medical Assessment | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Admission/Completion Letter | <input type="checkbox"/> Immunizations | <input type="checkbox"/> Aftercare Treatment Plan | <input type="checkbox"/> Psychological Testing |
| <input type="checkbox"/> Master Treatment Plan | <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> School Records | <input type="checkbox"/> Progress Notes |
| | | <input type="checkbox"/> Court Referral Form | <input type="checkbox"/> Employer Conference |
| Other _____ | | | <input type="checkbox"/> Assessment Findings & Recommendations |

3. Records may be disclosed via: ___ fax ___ mail ___ telephone, other _____

4. For purpose of: ___ Diagnosis/Treatment ___ Discharge/Aftercare Planning ___ Progress Report

Other _____

5. I understand that I have a right to revoke this authorization at any time. To revoke this authorization, I must submit a written request to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization.

6. This authorization will expire on the following date or event: _____

7. Generally, Rimrock Foundation will not condition treatment on the provision of this authorization, unless services are solely for the purpose of creating information for disclosure to a third party.

8. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may no longer be protected by federal confidentiality rules.

9. I have received a copy of this authorization.

Signature of Patient _____ Date _____ Parent/Personal Representative _____ Date _____

If the Patient is a minor (under age 18), both the Patient and parent or legal guardian must sign. If signed by a personal representative, nature of the personal representative's authority to act for the Patient: _____

NOTICE TO WHOMEVER DISCLOSURE IS MADE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.