ALLUVION HEALTH

601 1st Avenue North, Great Falls, MT. 59401 Phone: (406) 454-6973 Fax: (406) 791-9277

PATIENT AUTHORIZATION TO OBTAIN OR RELEASE PROTECTED HEALTH INFORMATION

Name:	DOB:	SSN:	Phone:
Address:	City:	State:	Zip Code:

INFORMATION TO BE OBTAINED FROM:

Elaine A. Barbieri, MD
Name of Facility or Provider

401 15th Ave S
Address

Great Falls, MT 59405
City, State, Zip Code

406-771-9050 / ______
Phone Number / Fax Number

INFORMATION TO BE RELEASED TO:

Community Health Care Center LLC dba Alluvion Health
Name of Facility, Provider, Person, or Self.

601 1st Ave N
Address

Great Falls, MT 59401-2510
City, State, Zip Code

406-454-6973 / 406-791-9277
Phone Number / Fax Number

INFORMATION TO BE RELEASED:

☑ Medical Records (medical care only) date ____/____/____ to ____/____/____
Include:
- ☑ HIV/AIDS records*
- ☑ Communicable Disease*
- ☑ Reproductive Health*

☐ Behavioral/Mental Health Records* date ____/____/____ to ____/____/____
Include:
- ☐ Substance Abuse Treatment & Diagnosis*

☐ Dental Records date ____/____/____ to ____/____/____

☐ Specific instructions: ______________________

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE:

☑ Provider ☐ Personal ☐ Verbal Only ☐ Other: ______________________

PATIENT AUTHORIZATION:

MY RIGHTS:
I understand that if I should decide to not sign this Authorization there will be no retaliation from Alluvion Health nor will there be any effect on my treatment or payment for services Alluvion Health 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 do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). **I may revoke this authorization in writing at any time**. To revoke this Authorization please mail notice of revocation to Alluvion Health, Attention: Privacy Officer at the address noted above. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Law.

This Authorization will expire 365 days from the date signed unless otherwise noted: date ____/____/____

Signature: ______________________________________ **Date:**______________________________
(Patient, Guardian, or Authorized Representative)

Received By:__________________________________ **Date:**______________________________

*If any of the individual boxes under Medical Records or any box relating to Behavioral/Mental Health Records are checked above, the signature must be that of PATIENT, including a minor patient. Consent for release of those specific records can **only** be given by the minor patient. 42 CFR § 2.14(a); Mont. Code Ann. § 41-1-402. If signed by conservator or person 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 protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see 42 CFR § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 42 CFR §§ 2.12(c)(5) and 2.65.

NOTICE TO PATIENT OF FEDERAL CONFIDENTIALITY REQUIREMENTS: Federal law and regulations protect the confidentiality of substance use disorder patient records. The limited circumstances under which Alluvion Health may acknowledge that an individual is present or disclose outside its program information identifying a patient as having or having had a substance use disorder include with the patient's written consent under 42 CFR part 2, if authorized by a court order under 42 CFR part 2, in certain medical emergencies, for certain scientific research, and for certain audits and evaluations of Alluvion Health. *See* 42 CFR §§ 2.13(c), 2.51-2.53. Violation of federal law and regulations regarding patient record confidentiality is a crime. Suspected violations may be reported to appropriate authorities consistent with 42 CFR § 2.4, to the United States Attorney for the judicial district of Montana as well as to a Substance Abuse and Mental Health Services Administration (SAMHSA) office responsible for opioid treatment program oversight in Montana. Information related to a patient's commission of a crime on the premises of Alluvion Health or against personnel of Alluvion Health is not protected. Reports of suspected child abuse and neglect made under state law to appropriate state or local authorities are not protected. 42 CFR § 2.22.