PLEASE RETURN RECORDS BY:_____

3139 41st St NW
Rochester, MN 55901
Phone: (507) 923-7321
Secure Email: info@riverstonepsych.com

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, Patient Name (Print) _____ Date of Birth _____,

Authorize Riverstone Psychological Services, Inc. to Exchange Information with:

_____

Address _____ City _____ State _____ ZIP _____

Phone: _____ Fax: _____

Information to be exchanged:

- ☐ Patient Status
- ☐ Relevant Verbal Information
- ☐ Diagnosis
- ☐ Treatment/ Discharge Summary Reports
- ☐ Evaluation Reports
- ☐ Test Data
- ☐ Psychotherapy Notes
- ☐ Other _____
- ☐ **Exchange of information by email/ fax/ mail permitted**

Purpose of disclosure:

- ☐ Coordination of Care
- ☐ Court-order
- ☐ Other _____

This authorization will **expire** on _____ or one year after the date of this signature, whichever is longer.

I understand that

- My health information is regulated by federal regulation (Alcohol and Drug Abuse Patient Records, 42 CFR Part 2: and/or HIPAA 45 CFR) and state privacy laws; and that disclosure is allowed only with my authorizations except in limited circumstances described in Riverstone Psychological Services, Inc.'s Privacy Notice. I understand that I have a right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws.
- I can revoke this authorization at any time, except (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, a written request must be submitted. For disclosures other than for treatment, payment and healthcare operations purposes, treatment may not be conditioned on my agreement to sign this authorization (unless I am receiving care solely to create protected health information for disclosure to a third party) (45 CFR & 164.508 (b)(4)(III)
- Communications resulting from this authorization will reveal that I receive services at Riverstone Psychological Services, Inc.
- Federal confidentiality regulations (at 42 CFR Part 2) prohibit re-disclosure of information from alcohol and drug abuse patient records. However, HIPAA requires Riverstone Psychological Services Inc., to notify me of the potential that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by HIPAA rules.
- This authorization may be disclosed by Riverstone Psychological Services, Inc. owned or managed programs upon transfer of my care to them.

I voluntarily authorize the release of my confidential/ protected health information, as described in the directions above. I have read and understand the information regarding my rights and HIPPA provided on the back side of this page.

_____

Patient Signature (Or, patient's parent/ legal guardian, if patient is younger than 18 years-old) **Date**

_____

Signature of Witness **Date**

Information disclosed to you from records protected by the 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 information is not sufficient for this purpose.