



Holcomb Johnston, N.D.

123 W. Main Street

Bozeman, MT 59715

PHONE: (406)599-3349

WWW.SWEETGRASSMEDICINE.COM

Authorization & Request to Release Protected Health Information

Patient name: _____ S.S. #: _____

Address: _____ D.O.B. _____

As required by the Privacy Regulations, SWEETGRASS NATURAL MEDICINE may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize: _____ Phone#: _____

Address: _____

Street

City

State

Zip

to disclose my Patient Health Information to Sweetgrass Natural Medicine.

By **INITIALIZING** the spaces below, I authorize the release of the following records:

- Entire Medical Record Progress Notes Laboratory Reports
- Pathology Reports EKG Imaging (X-ray, US, MRI, CT)
- HIV/AIDS related records Drug/Alcohol related treatment
- Mental Health records Genetic Testing information
- Other _____

For the time period:

- Previous month Previous ___ months Entire record

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.
7. I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

or Patients Authorized Representative _____ Date _____ Signature of Patient