# Authorization to Disclose Health Information
# Orchard School Clinic

I authorize RiverStone Health disclose to _____ School the following protected health information ("protected health information") of _____ (the "Student"), including all of the following unless otherwise indicated below:

- Information required by law;
- Conditions which may require emergency treatment;
- Conditions which limit the Student's daily activities; and
- Conditions which require the Student to be absent from school.

By signing this authorization, I understand that I am authorizing the RiverStone Health to use or disclose the Student's protected health information to Orchard School for the purpose(s) I have identified. I understand I can revoke this Authorization in writing at any time and doing so will stop future use or disclosure of the Student's protected health information; but I understand that RiverStone Health can act on this Authorization until either I revoke my authority in writing or until the expiration date in this authorization. If I want to revoke this Authorization, I will send written notice of revocation to RiverStone Health at 123 South 27th Street, Billings MT 59101 Attn: Medical Records.

I understand I can refuse to sign this Authorization and I am signing it of my own free will. I understand that if I should decide to not sign this Authorization there will be no retaliation from RiverStone Health, nor will there be any effect on the Student's treatment or payment for services.

I understand I can see and copy my protected health information as described in RiverStone Health's Notice of Privacy Practices. I understand RiverStone Health cannot control any further disclosure of my protected health information by Orchard School after it is disclosed as allowed by this Authorization, and that my protected health information may not be subject to continued protection under federal law once it is received by the recipient.

Unless I indicate at an earlier time below, this Authorization expires on the date the Student is no longer enrolled in the Orchard School Clinic or is no longer a student at _____ School.
Earlier expiration of Authorization: _____.

I have read and understand the release of protected health information described in this Authorization. My signature indicates my consent to release protected health information as specified.

Signature: _____ Date: _____
Parent/Guardian

Printed Name of Parent or Guardian: _____

Updated 6/13/16