WESTERN MONTANA
MENTAL HEALTH CENTER

Authorization to Release Health Record Information

Name: _____ **Date of Birth:** _____

Address (mailing) _____ **Phone:** _____

_____

I authorize Western Montana Mental Health Center to:

____ **receive from**

____ **release to**

the following individual or agency information from my health record.

Name: _____ **Phone:** _____

Address: _____ **Fax:** _____

_____

Dates of Treatment: _____ **to** _____

Information to be disclosed (please initial all that apply):

	Assessment		Medications List		Peer Support Notes
	Treatment Plan		Discharge summary		Nursing notes
	Progress Notes		Crisis evaluation		PACT notes
	Medical Notes		Group Home Notes		Crisis facility notes
	Consults		Day Treatment Notes		Safety plan
	Presence in treatment		Case Management Notes		Other

Purpose of Disclosure: _____

Please Read and Initial:

___ I understand this could include information related AIDS or HIV, psychiatric or mental healthcare, and/or substance use diagnoses and treatment.

___ I understand that, unless revoked, this authorization will expire one (1) year from the date of my signature or as follows, whichever occurs sooner. Specify date, event, or condition upon which this consent expires.

_____

___ I understand I may revoke this authorization at any time by notifying Administration at Western Montana Mental Health Center in writing at 1321 Wyoming Street, Missoula, MT 59801. This authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

___ I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations unless the recipient is subject to Federal or State laws prohibiting re-disclosure.

___ I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment from Western Montana Mental Health Center except where disclosure of the information is necessary for treatment.

___ I understand I may request and receive a copy of this form after I sign it.

___ I have received a copy of Western Montana Mental Health Center's Notice of Privacy Practices.

By signing below, I acknowledge I have read and understand this Authorization.

Client or Guardian Signature: _____ **Date:** _____

Guardian Printed Name, if applicable: _____

Relationship to Client: _____