WESTERN MONTANA
MENTAL HEALTH CENTER

Authorization to Release Health Record Information – Substance Use Disorder

NAME:_____DOB:_____SSN: _____

Hereby authorizes Western Montana Mental Health Center to the following (initial all that apply) via the following means:

_____ RELEASE TO_____OBTAIN FROM

_____ ELECTRONIC_____VERBAL _____WRITTEN

Name:_____**Relationship:**_____

Agency:_____

Address: _____

Phone:_____**FAX:**_____ **e-mail**: _____

Specific Information to be RELEASED or OBTAINED (initial all that apply):

	ACT Records		Discharge Medications		Pre-Sentence Investigation
	Admission/Compliance Status		Discharge Summary		Progress Notes/MD Notes
	Bio-Psych-Social Info.		Family Program Info		Progress Report
	Continued Stay Reviews		History/Physical		Psychiatric Evaluation/Records
	Continuing Care Plan		Intake/Assessment Summary		Treatment Plan
	Demographic Info		Lab Tests (re-release)		Treatment Recommendations
	Diagnostic Impressions		Presence in Treatment		

_____ Re-Release of Records (Specify Record(s): _____

PURPOSE FOR DISCLOSURE:

_____

Please Read and Initial:

_____I understand this could include information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Syndrome Virus), Psychiatric or Mental Health Care, Treatment for alcohol and/or drug abuse.

_____I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

_____ 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 submitting a written request to the Administration at Western Montana Mental Health Center, 1321 Wyoming Street, Missoula, MT 59801**.** I understand that the revocation will not apply to information that has already been released in response to this authorization, including provision of treatment and disclosing information to third party payers.

_____I understand that generally Western Montana Mental Health Center may not condition my treatment on whether I sign this authorization form, but that in certain circumstances, such as for treatment purposes, I may be denied treatment if I do not sign an authorization form.

_____I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may no longer be protected by federal confidentiality rules.

_____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 Rights.

CLIENT SIGNATURE:_____Date: _____

GUARDIAN SIGNATURE:_____Date: _____

Relationship to client: _____

NOTICE TO WHOMEVER DISCLOSURE IS MADE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. 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 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.