

**MONTANA STATE HOSPITAL
CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION**

I, _____ (D.O.B) _____ (PT. #) _____,
(Name of Patient or Participant)

authorize Montana State Hospital to disclose Protected Health Information to:

_____ (name)

_____ (address)

_____ (address)

I authorize the disclosure of the following Protected Health Information within the date range of

_____ (start date) to _____ (end date):

- | | | |
|---|--|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Psychiatric Evaluations | <input type="checkbox"/> Psychological |
| <input type="checkbox"/> Physical Examination | <input type="checkbox"/> Social History | <input type="checkbox"/> Rehab. Therapy |
| <input type="checkbox"/> Laboratory Studies | <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> HIV/AIDS Testing/Treatment |
| <input type="checkbox"/> Medications/MAR/Orders | <input type="checkbox"/> Legal Documents/FRB | <input type="checkbox"/> Advance Directives/Living Will |
| <input type="checkbox"/> Medical Consultations | <input type="checkbox"/> Alcohol/Drug Abuse Treatment/Referral | |

Other _____

The purpose or need for this disclosure is: _____

This authorization expires six months from the date of signature unless another date, event, or condition is stated here: _____

Executed this _____ day of _____, 20_____

You may revoke this authorization at any time, except to the extent that action has been taken in reliance on it, by giving written notice of revocation to Montana State Hospital at the address below

Mail to:
Health Information Dept
Montana State Hospital
PO Box 300
Warm Springs, MT 59756

Signature of Patient

Signature of Parent, Guardian or authorized representative (when required)

NOTICE:

Protected Health Information disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy law.

Montana State Hospital may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization.