**Mountain West Psychological Resources**

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**Authorization to Release Protected Health Care Information**

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| PATIENT | Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| FROM/TO | ***I authorize the use and/or disclosure of the health information described below for the above-named patient by the following entities:*** |
| **Information is to be released from:** | **Information is to be disclosed to**: |
| PURPOSE | **For the purpose(s) of**: [ ] Request of patient or representative [ ] Coordination of care [ ] Assist with evaluation, diagnosis, and treatment plan [ ] Legal proceedings [ ] Independent or Forensic Psychological/Neuropsychological Examination [ ] Research [ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| INFORMATION TO BE DISCLOSED | **Description or nature of the disclosed information** (initial all that apply) |
| \_\_\_\_\_ Admission Summaries\_\_\_\_\_ Discharge Summaries\_\_\_\_\_ Medication Records\_\_\_\_\_ History/Physical Exams\_\_\_\_\_ Medical Progress Notes\_\_\_\_\_ Nursing Notes\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_ Neurology Progress Notes\_\_\_\_\_ CT Scan or Brain\_\_\_\_\_ MRI of Brain\_\_\_\_\_ MRA of Brain and Neck\_\_\_\_\_ EEG Reports\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ***Specially Protected Information***\_\_\_\_\_ Psychotherapy Progress Notes\_\_\_\_\_ Psychological/Neuropsychological Evaluation\_\_\_\_\_ Psychological/Neuropsychological Test Scores\_\_\_\_\_ Substance Abuse Treatment Records\_\_\_\_\_ HIV/AIDS and STD Information\_\_\_\_\_ Academic/IEP Records\_\_\_\_\_ Legal Records |
| \_\_\_\_\_ Any or all health records listed above (excluding Specially Protected Information unless otherwise initialed) |
| \_\_\_\_\_ Other Information (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| NOTICES | 1. I understand that if the recipient of the information disclosed under this authorization is not a health plan or provider covered by federal or state laws, the information may be re-disclosed by the recipient and no longer protected by those laws. If the information being disclosed under this authorization contains HIV/AIDS, STD, mental health, substance abuse diagnosis and treatment, or genetic testing, Federal law and regulations including 42 CFR Part 2 and 45 CFR Parts 160 and 164 or state law may prevent the recipient from re-disclosing this information.
2. I can refuse to sign this authorization. My refusal will not adversely affect my ability to receive treatment, to enroll in a health plan, to be eligible for health care benefits, or to obtain payment for services unless this authorization is sought for purposes of research-related treatment, to determine my eligibility or enrollment in a plan, for underwriting or risk determinations or if the services related to the information to be disclosed are performed solely for the purposes of providing that information to someone else.
3. I may revoke this authorization at any time by appropriate written notification provided to the above-named disclosing entity on its designated form. Any such revocation will not apply to any activity already undertaken based on this authorization.
4. I can receive a copy of this authorization, and I may inspect and request copies of information disclosed by this authorization.
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| DATES | Unless revoked, this authorization is valid for 90 days from the date of signature, or for the following time period:Beginning Date: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ Ending Date \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ Not to exceed one year |
| SIGN | ***Signature: I have read this authorization and understand it.***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_Signature of Patient or Representative Relationship to Patient (if not self) Date |