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):

___ Discharge Summary	____ Psychiatric Evaluations	___Psychological
___ Physical Examination	____ Social History	___Rehab. Therapy
___ Laboratory Studies	____ Treatment Plan	___HIV/AIDS Testing/Treatment
___ Medications/MAR/Orders	____ Legal Documents/FRB	___Advance Directives/Living Will
___ Medical Consultations	____ 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.