AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Full Name of Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone No: _____ Date of Birth: _____

To: I authorize (Facility), _____
(Facility, Address: City, State, Zip Code)

Fax: _____Phone: _____ and the following named organization and/or person(s) to communicate with and disclose to one another the following protected health information ("my protected health information")

From: _____ Fax: _____ Phone: _____
(Name of Individual(s)/Provider or Agency)

Address: _____City: _____State: _____ Zip: _____

(Please Initial)

- ☐ All Medical Records _____
- ☐ Progress Note(s) _____
- ☐ Lab Results _____
- ☐ Mental Health Information _____
- ☐ Chemical Dependency_____
  (If checked see back)

(Please Initial)

- ☐ X-Ray Reports_____
- ☐ Consultations _____
- ☐ Immunizations _____
- ☐ AIDS/HIV_____
- ☐ Other (Please Specify and Initial) _____
  _____

All Records from this Date: _____ To this Date: _____

I authorize the release of my protected health information for the following purpose(s):

- ☐ At the request of the individual
- ☐ Other (Please Specify): _____
- ☐ If this box is checked, Facility may discuss my protected health information with the individual or entity named above.

By signing this authorization, I understand that I am authorizing Facility to use or disclose my protected health information for the purpose(s) I have identified. I understand I can revoke this Authorization in writing at any time, unless Facility has already acted in reliance on it, and such revocation will stop future use or disclosure of my protected health information. I understand that Facility can act on this Authorization until either I revoke my authority in writing or until the expiration date in this Authorization. If I want to revoke this Authorization, I will send my written notice of revocation to Facility as follows:

ATTN: Privacy Officer
Leslie Jensen
406-535-6545 Ext. 435
leslie.jensen@onechc.org

I understand I can refuse to sign this Authorization and I am signing it of my own free will. I understand that if I should decide to not sign this Authorization there will be no retaliation from Facility nor will there be any effect on my treatment or payment for services Facility provides, unless this Authorization is required in order for me to participate in a research project or clinical trial, in which case I realize I may not be eligible for such project or clinical trial unless I authorize the use or disclosure of my protected health information. I understand I can see and copy my protected health information as described in Facility's Notice of Privacy Practices Policy. I understand Facility cannot control any further disclosure of my protected health information by those who received it after it is disclosed as allowed by this Authorization, and that my protected health information may not be subject to continued protection under federal law once it is received by the recipient.

I understand that I will receive a copy of this Authorization after it is signed. Photocopies or faxed copies of this signed Authorization shall be treated as executed originals.

Unless I indicate an earlier time, this Authorization expires thirty (30) months from the date I sign: _____

***Patient or Legal Representative Signature:** _____Date: _____
Explanation if Not Signed by Patient:

_____Date: _____
Witness Signature

*The signature must be that of PATIENT. A parent or guardian must sign if the patient is a minor (under 18) or under guardianship proceedings (if signed by a guardian or under legal authority to act for the patient, or if this Authorization is signed by a personal representative of a deceased patient, proof of authority to act is required).

AUTHORIZATION FOR RELEASE OF SUBSTANCE USE INFORMATION

Information to be Disclosed:

☐ACT/Prime for Life Attendance ☐Treatment Status ☐Progress Notes
☐ACT Evaluation ☐Court Referral ☐Discharge Summary
☐Assessment Findings/Recommendations
☐Other:

Purpose of Disclosure:

☐Diagnosis/Treatment ☐Coordination of Care ☐Compliance with Court Order
☐Other:

***Patient or Legal Representative Signature:** _____Date:_____
Explanation if Not Signed by Patient:

_____ Date: _____
Witness Signature

*The signature must be that of PATIENT. If the patient is a minor, consent may be given only by the minor patient. 42 CFR § 2.14(a); Mont. Code Ann. § 41-1-402. If signed by conservator or person under legal authority to act for the patient, or if this Authorization is signed by a personal representative of a deceased patient, proof of authority to act is required.

NOTICE TO WHOMEVER DISCLOSURE IS MADE: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see 42 CFR § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 42 CFR §§ 2.12(c)(5) and 2.65.

NOTICE TO PATIENT OF FEDERAL CONFIDENTIALITY REQUIREMENTS: Federal law and regulations protect the confidentiality of substance use disorder patient records. The limited circumstances under which Facility may acknowledge that an individual is present or disclose outside its program information identifying a patient as having or having had a substance use disorder include with the patient's written consent under 42 CFR part 2, if authorized by a court order under 42 CFR part 2, in certain medical emergencies, for certain scientific research, and for certain audits and evaluations of Facility. *See* 42 CFR §§ 2.13(c), 2.51-2.53. Violation of federal law and regulations regarding patient record confidentiality is a crime. Suspected violations may be reported to appropriate authorities consistent with 42 CFR § 2.4, to the United States Attorney for the judicial district of Montana as well as to a Substance Abuse and Mental Health Services Administration (SAMHSA) office responsible for opioid treatment program oversight in Montana. Information related to a patient's commission of a crime on the premises of Facility or against personnel of Facility is not protected. Reports of suspected child abuse and neglect made under state law to appropriate state or local authorities are not protected. 42 CFR § 2.22.