

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Phone No:	Address:	City:	State:	Zip:
From:	Phone No:	Date of Birth:		
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:	To : I authorize (Facility),			
From:			nd/or norcon(s) to so	mmunicata with and
Address: City: State: Zip:				minianicate with and
Address: City: State: Zip:	From:	Fax:	Pho	ne:
Please Initial	(Name of Individual(s)/Provider or Agency)			
All Medical Records	Address:City:	State:	Zip:	
Progress Note(s)	(Please Initial)	(Please Initial)		
Progress Note(s)	☐ All Medical Records	X-Ray Reports_		
Lab Results		☐ Consultations _		
Mental Health Information	☐ Lab Results			
Chemical Dependency	☐ Mental Health Information			
thorize 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. signing this authorization, I understand that I am authorizing Facility to use or disclose my protected health information for the pose(s) I have identified. I understand I can revoke this Authorization in writing at any time, unless Facility has already acted in relial t, and such revocation will stop future use or disclosure of my protected health information. I understand that Facility can act on the horization until either I revoke my authority in writing or until the expiration date in this Authorization. If I want to revoke this horization, I will send my written notice of revocation to Facility as follows: ATTN:		☐ Other (Please S	pecify and Initial)	
thorize 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. Signing this authorization, I understand that I am authorizing Facility to use or disclose my protected health information for the pose(s) I have identified. I understand I can revoke this Authorization in writing at any time, unless Facility has already acted in reliat, and such revocation will stop future use or disclosure of my protected health information. I understand that Facility can act on the horization until either I revoke my authority in writing or until the expiration date in this Authorization. If I want to revoke this horization, I will send my written notice of revocation to Facility as follows: ATTN: Privacy Officer Lesile Jensen 406-535-6545 Ext. 435 Lesile Jensen 406-535-6545 Ext. 435 Lesile Jensen will be no retaliation from Facility nor will there be any effect on my treatment or payment for services Facility provides, unless this Authorization 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 thorize the use or disclosure of my protected health information. I understand I can see and copy my protected health information by those whived it after it is disclosed as allowed by this Authorization, and that my protected health information may not be subject to continued protection er federal law once it is received by the recipient. derstand that I will receive a copy of this Authorization after it is signed. Photocopies or faxed copies of this signed Authorization shall be treated a cuted originals. East I indicate an earlier time, this Authorization expires thirty (30) months from the date I sign: Date: Date:	(If checked see back)			
ess I indicate an earlier time, this Authorization expires thirty (30) months from the date I sign:	thorize the release of my protected health information for the At the request of the individual If this box is checked, Facility may discuss my prote	e following purpose(s): Other (Please Specify): cted health information with	n the individual or en	tity named above.
tient or Legal Representative Signature:Date:	thorize the release of my protected health information for the At the request of the individual CI If this box is checked, Facility may discuss my protesigning this authorization, I understand that I am authorizing Fpose(s) I have identified. I understand I can revoke this Authot, and such revocation will stop future use or disclosure of my horization until either I revoke my authority in writing or until horization, I will send my written notice of revocation to Facility derstand I can refuse to sign this Authorization and I am signing it of the will be no retaliation from Facility nor will there be any effect on maired in order for me to participate in a research project or clinical trickhorize the use or disclosure of my protected health information. I unlity's Notice of Privacy Practices Policy. I understand Facility cannot derived it after it is disclosed as allowed by this Authorization, and that	e following purpose(s): Other (Please Specify): cted health information with facility to use or disclose my rization in writing at any time protected health information the expiration date in this facility as follows: I the expiration date in this facility as follows: I my own free will. I understand my treatment or payment for second, in which case I realize I may inderstand I can see and copy meant for langing further disclosure or control any further disclosure or control and control	n the individual or enterprotected health inforce, unless Facility has on. I understand that Authorization. If I wan ATTN: Privacy Office Leslie Jense 406-535-65 leslie.jense that if I should decide tryices Facility provides, not be eligible for such y protected health inforce from the protected health inforce the protected health inforce the protected health inforce from the protected health inforce the protected health inforc	tity named above. ormation for the already acted in relian Facility can act on the at to revoke this er en 645 Ext. 435 n@onechc.org o not sign this Authorizatio project or clinical trial crmation as described in aformation by those who
	thorize the release of my protected health information for the At the request of the individual Of If this box is checked, Facility may discuss my protesigning this authorization, I understand that I am authorizing Fpose(s) I have identified. I understand I can revoke this Authorit, and such revocation will stop future use or disclosure of my horization until either I revoke my authority in writing or until horization, I will send my written notice of revocation to Facility derstand I can refuse to sign this Authorization and I am signing it of re will be no retaliation from Facility nor will there be any effect on maired in order for me to participate in a research project or clinical tricthorize the use or disclosure of my protected health information. I unlity's Notice of Privacy Practices Policy. I understand Facility cannot clived it after it is disclosed as allowed by this Authorization, and that er federal law once it is received by the recipient.	e following purpose(s): Other (Please Specify): cted health information with facility to use or disclose my rization in writing at any time protected health information at the expiration date in this facility as follows: my own free will. I understand my treatment or payment for second in which case I realize I may inderstand I can see and copy motor any further disclosure or my protected health information.	n the individual or enter protected health inforce, unless Facility has on. I understand that Authorization. If I wan ATTN: Privacy Offic Leslie Jense 406-535-65 leslie.jense that if I should decide to rvices Facility provides, not be eligible for such y protected health inforce may not be subject to may not be subject to the protected health inforce may not be	tity named above. formation for the already acted in reliar Facility can act on this at to revoke this formation as described in a formation by those who continued protection
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*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).

11/2021

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: 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 <u>only</u> 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.