Center for Mental Health

Authorization for Release of Information

Case #: _____

www.center4mh.org

★ Date Signed: _____

915 – First Avenue South
Great Falls, MT 59401

Telephone: (406) 761-2100

FAX: (406) 761-2107

★ Patient's Name: _____ _____ _____ _____ _____
Last *First* *MI* *SSN* *DOB*

MAIDEN NAME *OR ANY* PREVIOUS NAMES USED: _____

_____ _____ _____ _____ _____
Street Address *City* *State* *Zip Code* *Phone Number*

SECTION A: USE OR DISCLOSURE OF HEALTH INFORMATION

By signing this Authorization, I authorize the use or disclosure of my Protected Health Information.

★ ***Please initial on the appropriate blank(s):***

_____ Initials I authorize the Agency / Individual to ***RELEASE*** my Protected Health Information, as stipulated under **Section B**, whether generated by that agency/individual, or by any other source, **to the Center for Mental Health**:

_____ Initials I give authorization for the Center for Mental Health to ***PROVIDE*** my Protected Health Information, whether generated by the Center for Mental Health, or any other source, **to the following Agency / Individual:**

★ ***PLEASE PRINT LEGIBLY:*** *(Not valid if left blank)*

Name of Individual or Agency		Area Code - plus Telephone #
Caduceus Medical Partners, LLC	Dr Michael Uphues, DO	( )
724 Grand Ave, Billings, MT		59101
Address	*City* *State*	*Zip Code*

Health information includes information collected from me or created by the Provider, or information received by the Provider from another health care provider, a health plan, my employer or a health care clearinghouse. Health information may relate to my past, present or future physical or mental health condition, the provision of my health care, or payment for my health care services.

Any provider that operates a Federally-assisted alcohol or drug abuse program is prohibited from disclosing information about treatment for alcohol or drug abuse without my specific written authorization unless a disclosure is otherwise authorized by Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).

SECTION B: SCOPE OF USE OR DISCLOSURE

Health information that may be used or disclosed through this Authorization is as follows:

★ ***Please initial on the appropriate blank(s):***

_____ Initials All health information about me, including my clinical records created or received by the Provider, *including* psychotherapy notes. This information may include, if applicable;

_____ Initials Information pertaining to the identity, diagnosis, prognosis or treatment for alcohol or drug abuse maintained by a Federally-assisted alcohol or drug abuse program;

_____ Initials All health information about me as described in the preceding , **excluding** the following: _____

_____

_____ Initials Specific information including only: _____

_____

OR Describe the health information to be **excluded or included** in a specific and meaningful fashion: _____

_____

SECTION C: PURPOSE OF THIS AUTHORIZATION TO USE OR DISCLOSE

Please initial on the appropriate blank(s):

_____ Initials Specifically, the following purpose(s) - **CONTINUATION OF CARE**

_____

_____ nitials The request for information to be used or disclosed has been initiated by the Patient and the Patient does not elect to disclose its purpose.

ECTION D: EXPIRATION

*his Authorization shall remain in effect until either **revoked by the client** or **six (6) months after the cessation of all services**.*