AUTHORIZATION TO RELEASE INFORMATION

Western Montana Mental Health Center

Gallatin Mental Health

Hope House

Livingston Mental Health

Center

Phone: (406) 585-1130

Center

Phone: (406)556-6500 Fax: (406) 522-8361 Fax: (406) 556-6591

Phone: (406) 585-5120 Fax: (866) 991-6986

PLEASE NOTE: If you are a recipient of information released by Western Montana Mental Health Centers, the following Federal Law applies directly to you: "This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (45 C.F.R., Parts 160& 164 and 42 C.F.R., Part 2) prohibit you from making any further disclosure if it is without the specific written consent of the person to whom it permits, or as otherwise permitted by such regulations. A general authorization or release of medical information is NOT sufficient for this purpose."

CLIENT NAME	DOB	SSN		
Hereby authorizes Western Montana Mental	Health Center to do the follo	owing:		
Release TO Obtain FROM	Electron	nicVerbal	Written	
Individual or Agency:DR MICHAEL R. UF	PHUES, DO			
Address: 724 GRAND AVENUE, BILLINGS	S, MT 59101			
Phone: 406-696-0409	Fax:406	Fax: 406-969-2447		
Specific Information to be RELEASED or OBTA	AINED (please initial ch	oices):		
Designated Record Set Includes: clinical	l intake, initial assessment, las	t three med notes		
 X Discharge Summary X Progress Notes (Therapist's notes) Adult Case Management Notes Aftercare Planning X Medical Evaluation / Office Visits 	X Medication List Emergency Consultations / CRT Notes Hope House Records HH Progress Notes (CIW Notes)			
Other Records (specify):			all halo, race of the control of the	
I understand this could include information related to AIDS or HIV	7, psychiatric or mental health care, treatr	nent for alcohol and/or substa	nce abuse.	
THE PURPOSE/NEED FOR SUCH DISCLOSURE IS:				
I voluntarily allow the above named agencies to disclose/receive in other than those persons participating in my treatment continuum vexcept to the extent that action has been taken in reliance on it (e.g expires as described below. I authorize the use of telefax or photocommunications are the second to be a superior of the second telefax or photocommunications.)	without my written permission. I addition . – probation, parole, etc) and that, in any	nally understand that I may re- revent, this consent (unless ex	voke this consent at any time	
The facility, its employees, officers, and physicians are hereby releindicated and authorized therein. I understand that the program maindividual or agency.	ased from any responsibility or liability f y not condition my care to the signing of	or disclosure of the above inf (or the refusal to sign) a relea	ormation to the extent se of information for another	
This consent may be revoked at any time in writin expire upon termination of program services at the here:	g (forms available at WMMH) is facility unless another expir	C). Barring revocation attion date is otherwise	n, this consent shall e indicated	
CLIENT SIGNATURE:		Date:		

GUARDIAN/WITNESS SIGNATURE (if necessary):