AUTHORIZATION FOR RELEASE, DISCLOSURE AND EXCHANGE OF INFORMATION

Name of Participant: DOB:

Address (city/state/zip): Phone:

Name of Parent/Legal Guardian (if participant is under 18 years old):

I hereby request, consent to and authorize the mutual disclosure and exchange of information and records concerning the above-named participant by and between the organizations below:

Agency/Program Name: _____ Agency/Program Name: _____

Agency/Program Name: _____ Agency/Program Name: _____

Agency/Program Name: _____ Agency/Program Name: _____

Agency/Program Name: _____ Agency/Program Name: _____

The purpose for the disclosure and exchange of information is at my request and to facilitate the delivery of services, including service and care coordination and case management.

THE INFORMATION THAT I HEREBY AUTHORIZE FOR RELEASE AND EXCHANGE IS AS FOLLOWS (Please place your initials next to the types of information that you ARE AUTHORIZING for release / exchange):

- ☐ Medical
- ☐ Education
- ☐ Drug/Alcohol
- ☐ Mental Health
- ☐ HIV-Related
- ☐ Housing
- ☐ Limited Release (for Legal Services use only)[1]
- ☐ Other:

[1]Due to the confidentiality regulations for some agencies such as legal services providers operating under specific rules of confidentiality and privilege, it may be recommended by the referring agency that the participant only give a limited release. This limited release means that the referring agency will only share basic information about the participant and the type of issue for which the participant seeks referrals. The participant can then choose to share more information, or sign an unlimited release after they become a client with the new agency.

My consent and authorization to this mutual disclosure and exchange of information and records is being granted with the following understandings on my part:

- That this consent and authorization is not valid without the required signature below;
- That my consent and authorization is being provided voluntarily, and that it will expire no later than one year from the date below unless I revoke it in writing prior to that time;
- That I have the right to revoke or modify this authorization at any time in writing, except to the extent that information may have already been disclosed pursuant to this consent and authorization;
- That I have the right to request a copy of this form after I sign it, and may have the right to inspect or copy any information shared or disclosed in accordance with this consent and authorization to the extent allowed for by state and federal law;
- That I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from at least certain of the providers outlined above. I also understand, however, that there may be consequences attendant to a decision on my part to not authorize the disclosure and sharing of information, i.e., that at least some of the organizations listed above may not be able to effectively provide services without it;
- That some of the information shared between the organizations listed above may be subject to various state and federal privacy laws, including but not limited to HIPAA, FERPA and/or the alcohol and drug abuse privacy regulations (42 C.F.R. Part 2), and that all of the organizations listed above agree to comply with those regulations to the extent they apply to their respective activities, including but not limited to any restrictions or allowances for the any further disclosure of information shared or provided to them in accordance with this consent and authorization;
- That when certain types of my information are used or disclosed pursuant to this authorization, they may be subject to re-disclosure by the recipient to others without my knowledge or further authorization, in which event applicable privacy laws may no longer protect my information;
- That, to the extent I am authorizing the disclosure of information above that specifically relates to alcohol or drug abuse, the entities to whom such disclosure and sharing has been authorized above ARE PROHIBITED from making any further disclosure of that information to any person or entity outside the group identified above, unless otherwise authorized permitted by 42 C.F.R. Part 2 or they receive express written consent for such further disclosure;
- Failure to sign this ROI will not affect the ability to obtain treatment from entities outlined above. The covered entities may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization.

Participant[2] - or Parent/Legal Guardian Signature _____ Date: _____

Witness _____ Date: _____

Please check applicable box below. If signing on behalf of patient, provide a copy of authorizing document for items marked below with an asterisk (*).

☐ Self ☐ Parent of minor child

☐ Legal guardian* ☐ Power of attorney* ☐ Other personal representative*

REVOCATION OF AUTHORIZATION / CONSENT

I hereby REVOKE the foregoing Authorization and Consent to Disclosure and Exchange of Information in its entirety.

Participant[2] - or Parent/Legal Guardian Signature _____ Date: _____

[2] Minors are authorized by Montana law (§ 41-1-401, et seq., MCA) to both (1) consent to the provision of health care services and (2) control access to protected health care information under certain limited circumstances (i.e., pregnancy, sexually transmitted disease, or substance and alcohol abuse). Any utilization of this form based on the signature of a minor student should be carefully reviewed by the agency to ensure such circumstances are applicable.