Release of Information instructions: Corresponding numbers can be found on the EXAMPLE Consent to Release form on the next page.

1. **Write your name and date of birth on the top line.**

2. **Fill in the name of the facility or person you want your information to be released to. Include their address, phone number and fax number.**

3. **Place an "X" next to the information you want to be released.**

4. **<u>Initial by ALL of the "X"s</u>**

5. **Write in the date you want the release to expire. One year is standard.**

6. **Sign and date the form.**

7. **Someone needs to witness your signature and sign and date.**

E-mail back to: maindesk@adsgc.org
or Fax: 406-587-1238

The following page is an example indicating the information you may wish to be shared. <u>Alter your release to the information necessary for your situation.</u> Please be aware that a failure to indicate what you want shared will delay your request. If this form is for ACT/PFL, please mark all items in red with an "X" before submitting your form.

ALCOHOL AND DRUG SERVICES OF GALLATIN COUNTY
CONSENT TO RELEASE AND/OR RECEIVE CONFIDENTIAL INFORMATION

1

I, _____, DOB, _____ authorize on my own accord Alcohol & Drug Services of Gallatin County, 2310 North 7th Avenue, Bozeman, MT 59715, Phone: (406) 586-5493, Fax: (406) 587-1238 to exchange my Chemical Dependency Treatment, Mental Health Treatment and Medical information with the party listed below. The information is to be released e.g., written, audio, video, fax, electronic, etc.

2

FACILITY / AGENCY: _____
PERSON: _____
PHONE: _____
ADDRESS: _____
CITY / STATE / ZIP: _____

The specific information indicated below with regard to the services provided to me for the following purpose(s):
(Initial next to check)

_____X_____ Chemical Dependency and/or Mental Health Treatment
_____ **Legal**
_____ Concerned Person Questionnaire
_____ MIP Requirements
_____ Other; specify: _____

3 & 4

My signature below authorizes the following reports to be furnished:
(Initial next to each check. Failure to initial next to the checkmark does not void the release of the information requested.)

_____ History and Physical
_____ Medical Discharge Summary
_____X_____ Chemical Dependency Discharge Summary/Note
_____ Mental Health Discharge Summary/Note
_____ Mental Health Status
_____X_____ Substance Abuse Psychosocial Assessment/Chemical Dependency Evaluation
_____ Mental Health Psychosocial Assessment/Mental Health Evaluation
_____ Treatment Plan
_____X_____ Consultations/Phone Contact
_____ Urinalysis Results
_____ **ACT (PFL) Transfer Information**
_____ MIP Transfer Information
_____X_____ Admittance, Progress, Participation, Results, & Recommendations
_____ Concerned Person Questionnaire Results
_____ Other; specify: _____

5

EXPIRATION DATE: _____

I understand that I may refuse to sign this form. Refusing to sign this form may affect my participation in the treatment program. I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent (42CFR Part 2). I may revoke this consent in writing at any time except to the extent that action has been taken in reliance thereon. This consent will expire automatically one year from the date this form is signed unless specified otherwise.

6

_____ _____
CLIENT SIGNATURE DATE

7

_____ _____
WITNESS (Adult-18 yrs. or older) DATE

_____
PARENT OR GUARDIAN SIGNATURE DATE

Revised 1/2018 NEW CONSENT