AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION*

OLIVE BRANCH PSYCHOTHERAPY
1601 2nd Ave. North, Suite 514, Great Falls, Montana 59401
Phone: (406) 217-2338

Client's Name: _____ Birth Date:_____

I, _____, authorize, Independent Practitioner, _____
Client Name Therapist's Name

at Olive Branch Psychotherapy to [release] [request] [share] (circle all that apply) confidential medical record information [to] [from] [with] (circle all that apply), _____ _____
Provider/Therapist/PCP Phone #

Information shall consist of: Duplicate records/ verbal consultation concerning treatment and/or education.

Specifically:

___ All Clinical Records	___ Psychological Evaluation	___ Educational Evaluation
___ Medical History	___ treatment, referral info	___ Discharge Summary
___ PCP Contract Form	___ Master Treatment Plan	___ Drug/Alcohol diagnosis
___ Mental Health Info	___ Drug/Alcohol tests & results	___ Other: _____
___ Social History	___ Psychiatric Evaluation	

The information is needed for the purpose of adopting a more comprehensive and integrated approach to my health care and maintaining a continuity of care for this purpose only unless other wise permitted or required by law.

This authorization may be revoked at any time by the client. Revoking of this authorization shall not cancel any prior action that has already transpired. If not revoked, it shall terminate the last day of the clinical treatment.

A photocopy, facsimile or duplicate copy of this authorization shall be as valid as the original.

The person signing this consent has a right to receive a copy of it. My initials, _____ indicate that I have received a copy of this authorization to release medical records.

I have read and understand the nature of this release. I understand that I may revoke it at any time. I release the director, therapists, employees and the above-named organizations from any liability that may arise from this action whether or not foreseen at present. I understand that certain medical records (including any alcohol and drug abuse information**) may be protected by Federal Regulations. **Drug Abuse Office and Treatment Act of 1972 21 U.S.C.
1175; Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (42 U.S.C. 4582).

_____ _____
Signature of Client Date

_____ _____ _____
Signature of Legal Representative (If client is a minor or incapacitated) Relationship to Client Date

_____ _____
Witness Date

I do not give my mental health provider permission to contact my primary care physician, therapist or other type of provider.

_____ _____
Signature of Client Date

***PRIVACY ACT STATEMENT**

1. T he authority for soliciting the information comes from 10 USC 3012
2. T he purpose for soliciting the information is to provide the therapist/counselor data to assist in counseling you are seeking.
3. T he information will be maintained under strict professional guidelines at the Family Institute, P.C. and until, by law, your records are released to be destroyed.
4. Providing the information is voluntary. T here will be no adverse effect on you for not furnishing the information other than that certain data might not otherwise be
available to the counselor/therapist to enable him/her to provide you the most effective therapy.