MINERAL COUNTY
Health Department

1203 5th Ave East P.O. Box 488
Superior, MT 59872
Phone (406)822-3564 Fax: (406)822-3745

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

_____ D.O.B ___/___/___
(Patients Legal Name)

I, _____

Authorize_____
(Person/ Facility) (Address) (City) (State) (Zip)

To release to or exchange information about the above listed patient with:

_____
(Person/Facility) (Address) (City) (State) (Zip)

The following specific information (please check)

_____Evaluation/Reports/Services_____
(Specify content needed)

_____ Medical Records_____
(Specify content needed)

Omit the following Information (please check)
_____ HIV/AIDS
_____ Sexually Transmitted Disease
_____ Drug and Alcohol History
_____ Psychological Information

Signature_____ Date_____

Witness_____ Date_____

I, the above signed, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

Expiration Date: _____/_____/_____

If no expiration date is indicated, consent expires six (6) months after it is signed. (Client's consent may be up to 30 months from date of signature ARM 50-1-527)

05/15/2017