



Montana Neurobehavioral Specialists

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AUTHORIZATION TO RELEASE / OBTAIN (circle one) PATIENT INFORMATION

Patient Name: _____ Patient D.O.B: _____

I authorize **Montana Neurobehavioral Specialists** to release / obtain protected health information as specified below. I understand that protected health information may include medical and/or psychological diagnoses, treatment history, dates of visits to the doctor, and unique demographic information.

I understand that pursuant to my authorization **Montana Neurobehavioral Specialists** will release all records generated through this office, this may include information regarding the diagnosis or treatment of AIDS (Acquired Immunodeficiency Syndrome) or infection with HIV (Human Immunodeficiency Virus), substance abuse (drugs and/or alcohol), psychiatric/psychological or mental health care, or sexually transmitted diseases.

I understand that I may restrict **Montana Neurobehavioral Specialists** from releasing / obtaining certain components of my records by indicating with my initials below:

Type of Information IDO NOT wish to have released

_____ Psychological Testing Data & Results

_____ Substance Abuse Treatment Notes

_____ Neuropsychological Testing Data & Results

_____ AIDS / HIV Information

I understand that **Montana Neurobehavioral Specialists** will not disclose psychotherapy treatment notes without my specific authorization.

I specifically authorize the release of psychotherapy notes during the dates stated below. (Signature) : _____

Information is to be released to:

Name of Agency: _____

Name of Doctor/Contact: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date Range of Records to Be Released (required): _____

Purpose of Information to be obtained / released (required): _____

Per my request this release shall expire on (required): _____

I understand that I may revoke this request in writing to **Montana Neurobehavioral Specialists** Privacy Officer as per this Practice's Notice of Privacy. I further understand that the information disclosed per this Authorization may be subject to redisclosure and may no longer be protected by the Health Information Portability and Accessibility Act.

I voluntarily allow the above named agencies to obtain / release information to facilitate my treatment. No threat or coercive measures have induced me to sign this authorization and I understand that my treatment is not contingent upon my signing this authorization

Patient/Legal Guardian Name (Printed)

Patient/Legal Guardian Signature

Date