

**Montana Mental Health Nursing Care Center
800 Casino Creek Drive
Lewistown, Montana 59457**

Authorization for Release of Information

Phone #: 406-538-7451

Fax #: 406-535-2863

Date: _____

I hereby give my permission to _____

To furnish the following information: _____

This information is to be released to: _____

Purpose or need of information: _____

Dates of treatment: From: _____ To: _____

I have been informed as to the type of information requested and the benefits and disadvantages of releasing this information, if known. I hereby give consent freely and voluntarily and understand that treatment services are not contingent upon my decision. I also understand I may revoke this consent at any time, but not retroactive to the release of information made in good faith.

Signature of patient or responsible party:

Date

Signature of requestor at facility:

Date

This authorization remains valid for 180 days from date of signature of resident or responsible party and the expiration date is: _____

No expiration event or date can be listed that is greater than 30 months.