

Arrowhead Psychological & Behavioral Sciences, LLC

1501 14th Street West, Suite 230

Billings, MT 59102

406-294-9510

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Client Name: _____

Previous Names: _____

Social Security #: _____ Birthdate: _____

Phone Numbers (Home) _____ (Work) _____

- This will authorize _____ (name, address, & phone number) to release information to Arrowhead Psychological & Behavioral Sciences, LLC
- This will authorize Arrowhead Psychological & Behavioral Sciences, LLC to release records to:

Name/Organization

Street Address

City State Zip Code

The following information is to be released (check appropriate boxes):

- | | | |
|--|--|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Operative Report | <input type="checkbox"/> EKG/ECHO Reports |
| <input type="checkbox"/> Counselor's Discharge Summary | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Emergency Department Reports |
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> X-Ray/Radiology Reports | <input type="checkbox"/> Psychological Tests |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Psychoeducational Test Reports |
| <input type="checkbox"/> Individual Education Plan | <input type="checkbox"/> School Records | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Chemical Dependency Evaluation Report | | _____ |
| <input type="checkbox"/> Chemical Dependency Treatment Summary | | _____ |

For the following date(s) of treatment or condition: _____
(Specify dates of treatment or condition)

I am requesting this information be released for the following purposes:

- Continued care by another provider Insurance claim purposes Attorney review Program Evaluation
- Other (specify): _____

- With the exception of psychotherapy notes, all records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness/testing will be released unless otherwise indicated by the checkmark here: _____
Please indicate any restrictions. (Specify): _____
- I understand I may revoke this authorization by written request at any time to the address listed at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- This authorization will automatically expire one year from the date of my signature, or a lesser period of time as specified here: _____. The expiration period noted here may exceed one year only in certain situations as specified by law.
- I understand there may be a retrieval and copy charge associated with the release.
- I understand that once information is released pursuant to this authorization, Arrowhead Psychological & Behavioral Sciences, LLC. can not prevent the re-disclosure of the information to another third party.
- I understand this authorization must be filled out completely and signed in order to be considered valid. A copy that has not been altered will be considered as valid as an original.
- Arrowhead Psychological & Behavioral Sciences, LLC. will not condition treatment on my signing this authorization.

Signature of Patient / Authorized Person
(If authorized person is signing, please also print name)

Authorized Person's Authority to sign Date
(Parent, guardian, power of attorney, etc.)

Reason patient is unable to sign: Minor Deceased Other: _____