

**Instar Community Services**  
**1824 North Last Chance Gulch, Helena MT 59601**  
**406-422-4828-office 406-431-1232-cell 406-422-5240-fax**

**Client Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_  
(Last) (First) (MI)

**Social Security Number:** \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF INFORMATION**

Extent or nature of disclosure is limited to: (Check all that apply) HIPAA standards require that you request the minimum information necessary to complete required purpose of this release.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Discharge Summary             | <input type="checkbox"/> History & Physical             | <input type="checkbox"/> Drug and alcohol tests and results |
| <input type="checkbox"/> Mental Health Assessment      | <input type="checkbox"/> Master Treatment Plan          | <input type="checkbox"/> Progress Notes                     |
| <input type="checkbox"/> Dates in program              | <input type="checkbox"/> Chemical dependency evaluation | <input type="checkbox"/> Diagnosis                          |
| <input type="checkbox"/> General Progress in Treatment | <input type="checkbox"/> Placement Options              |   |
| <input type="checkbox"/> Continued Stay Reviews        | <input type="checkbox"/> Correspondence (Letters)       |   |

Other (Please be specific): \_\_\_\_\_

**Date Release Revoked:** \_\_\_\_\_

Purpose of need for disclosure is: Continuity of Care

**Permission is hereby given to exchange information with:**

Instar Community Services	406-422-4828 phone
PO BOX 1811 (mailing address)	406-422-5240 fax
East Helena, MT 59635	

(To), (from), and (with) (circle all that apply):

The information you designate for disclosure will be disclosed from records protected by HIPAA privacy standards and Federal Confidentiality regulations (42 CFR Part 2). The Federal rules prohibit the recipient of the information from making any further disclosure of this information, unless further disclosure is expressly permitted by your written authorization, or as otherwise permitted by state and federal regulations. A general authorization for the disclosure of medical or other information is **NOT** sufficient for this purpose.

I, the undersigned, have read the above and authorize staff of the disclosing facility named to disclose such information as herein contained. I understand that I may revoke or cancel this authorization at any time. Withdrawal of the authorization does not affect any information disclosed before providing a written notice of such a withdrawal of authorization. **This authorization will remain in effect for one year in order to carry out the purpose for which my permission was given.** I understand that the program releasing these records is free from all legal liabilities that may arise from this act. I understand that I have the right to limit the information that is to be disclosed and who can see this information. A photocopy of this authorization is as valid as the original.

_____	_____	_____	_____
<b>Patient Signature</b>	<b>Date</b>	<b>Facility Witness Signature</b>	<b>Date</b>

Sign below to cancel permission to disclose the information described on this form.

_____	_____	_____	_____
Patient Signature	Date	Facility Witness Signature	Date

This notice accompanies a disclosure of information concerning a patient in alcohol/drug abuse treatment made to you with the consent of such patient. This information has been disclosed to you from records protected by Federal Confidentiality rules (42 CFR Part2) and the Health Insurance and Portability and Accountability Act of 1996 (HIPAA 45 C.F.R. Parts 160 & 164) Federal laws prohibit you from making any further disclosure of this information unless it is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 of HIPAA. The Federal rules and laws restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**Instar Community Services will not make signing this authorization a condition of treatment, payment or enrollment/eligibility for benefits unless the authorization is mandatory.**

Revised 08/05/2019