Big Sky Family Therapy

Stephanie Isbell, MA, LCPC

2831 Fort Missoula Road
Ste 300 Bldg 2
Missoula MT 59801

Phone: (406) 635-7114
Email: stephanie@revenons.com

Family Systems Trauma Therapy Advanced Certificate

DIR/Floortime Advanced Certificate

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH CARE INFORMATION

I hereby voluntarily authorize Big Sky Family Therapy to release and exchange copies of information from the medical records of the following client:

Client's Name: _____ Date of Birth: _____

TO: Provider name: _____ Provider address: _____

Phone number: _____ Fax number: _____

Information released for the following purposes:

☐ My personal record ☐ Communication with other health care providers as needed

☐ Other (please describe): _____

Information released for how long? **One Year** ☐ **OR** **Date range**: from _____ to _____

Information to be released:

☐ All medical records ☐ Physician notes ☐ Hospital records ☐ Physician notes

☐ Rehabilitiative therapy (PT, OT, Speech) ☐ Psychological/psychiatric/counseling records

☐ Other (specify): _____

I understand that the records released may contain the following information, which is protected by State and/or Federal law, and I authorize you to release this information (please check all those that apply):

☐ Mental health treatment ☐ Drug and alcohol abuse ☐ AIDS/HIV related information

I have read and understand the following and indicate with a check mark:

☐ This authorization expires one year after I sign it, or on this date. _____
The time period stated here may exceed one year only in certain situations specified by law. I may revoke this authorization at any time or by notifying Big Sky Family Therapy in writing.

☐ The authorization will cease to be effective on the date notified. This will not apply to records that have already been released.

☐ The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specifically protected information.

☐ Once the records are released, Big Sky Family Therapy cannot prevent them from being released to a third party.

☐ There may be a fee for releasing these records.

☐ To be valid, this authorization must be filled out completely and signed. A copy is valid if it has not been altered.

☐ If I do not sign this authorization, my healthcare and payment for my healthcare will not be affected; and will no jeopardize my right to obtain present or future treatment, except where disclosure of the information is required for treatment.

Signature of Client/legal guardian: _____ **Date:** _____

Relationship to client: ◉ **Parent** ○ **Guardian** ○ **Power of Attorney**

Reason client cannot sign: ◉ **Minor** ○ **Disability** ○ **Other:** _____