MONTANI MENTAL HEALTH

1137 Van Voorhis Road, Unit 44 Up

Morgantown, WV 26505

Phone: 304-282-0588

Release of Information

I, _____, herby authorize Montani Mental Health to

Release information to: _____

Address: _____

Phone Number: _____

Obtain information from: _____

Address: _____

Phone Number: _____

Exchange information with: _____

Address: _____

Phone Number: _____

The information requested or authorized for release or exchange pertains to (**circle all that apply**):

Mental Health Education HIV/AIDS STDs Drug or alcohol abuse

This authorization is valid for 1 year from the date below or _____, whichever is earlier. I may cancel this authorization by signing, dating, and writing "CANCEL" on this original form or by sending a written, signed and dated request to the doctor above indicating my desire to cancel. I understand that once my information has been released, the recipient might re-disclose it, my doctor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

_____ _____

Patients Name Date of Birth

_____ _____

Patients Signature Date

_____ _____

Guardian's Signature (if patient is a minor) Date