Katie M. McCall, PhD
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AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS & INFORMATION

I (we) _____authorize Dr. Katie McCall to give, exchange, or receive information from/with:

_____

(name & contact information for person/organization to whom disclosure will be made)

I would like the following information released:

☐ Medical History and evaluations ☐ Assessment and treatment history ☐ Other:

_____

I understand the purpose of the information exchange will be:

☐ To further mental health evaluation, treatment, or care ☐ Other:

_____

HIV and drug/alcohol information will be released with the above information unless this box is checked: ☐ do not release

I understand that:

☐ This consent will expire 90 days after the date on which it is signed, or upon fulfillment of the above stated purposes, whichever is longer.

☐ I understand that I may revoke this consent any time. I understand the revocation must be made in writing to Dr. McCall at 120 Hickory Street, Missoula Montana 59801.

☐ I understand that the parties in receipt of these communications may redisclose my PHI (protected health information) to persons or entities that are not subject to the HIPAA privacy regulations, resulting in my PHI no longer being protected by HIPAA regulations.

_____ _____ _____

Printed Name Date Signature