Helena, MT 59601
406/282-1744 (office phone)
capitalcityconsultants@gmail.com http://www.capitalcityconsultantsonline.com

This form when completed and signed, authorizes the release of protected information from you clinical record to the person you designate.

I authorize the release☐ or release and receive/exchange ☐ information by Capital City Consultants concerning the following information:

_____

_____

This information will be exchanged with only the following party:
Name:_____
Address:_____ City:_____ State:_____
Phone:_____ Fax:_____

This authorization shall remain in effect until : 30 days☐ 60 days☐ 360 days☐
or until☐ (fill in event that relates to the purpose or use of disclosure)_____ is completed.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to Capital City Consultants. However, your revocation will not be effective to the extent that Capital City Consultants has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim.

I understand that Capital City Consultants generally may not condition psychological services upon signing an authorization unless the psychological services are provided for the purpose of creating health information for a third party. I understand that the information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by HIPAA privacy rules. I need to establish limits of confidentiality with the recipient.

_____ _____

Client or Client Guardian date Witness date