State of Montana
Office of the Governor

Mental Health Ombudsman Office

Request for Assistance

Authorization to Release/Receive Information

Below is the information you have provided to the Mental Health Ombudsman. Please review it carefully. If necessary, make corrections or additions so that the information is as accurate and complete as possible.

Your name:_____SSN:_____

Your contact information-e-mail address_____

Work Phone_____Home Phone_____Cell Phone_____

Address_____

City_____ State_____ Zip_____

1. A brief explanation of the difficulty you are having:

    a. Agency(ies) that may share information from the Ombudsman:

    b. Please identify the type of information that may be shared with the Ombudsman:

This information will be disclosed from records whose confidentiality is protected by Federal Law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

2. What do you consider to be a fair resolution to your concern/issue?

3. On the back, provide any additional information you think would be helpful.

PLEASE ATTACH ANY DOCUMENTS RELATED TO YOUR CONCERN.

I have read this document and authorize the Office of the Mental Health Ombudsman to receive and exchange information from the agencies I have indicated above and to use this information to assist me in resolving the problem described above.

_____ _____

Signature Date

_____

Description of your authority to sign for the person requesting assistance, if applicable

This authorization to obtain and use confidential information expires *on the earliest of*: (1) when the requested assistance is completed or (2) 6 months from the date I signed above, or (3) the date my written notice of cancellation is received by the Mental Health Ombudsman (see directions for cancellation below).

Return by mail to: MHO – P O Box 200804 – Helena Montana 59620-0804 or by FAX to: 406-444-3543

I hereby authorize the office of the Mental Health Ombudsman for the State of Montana to make inquiries on my behalf. I understand that I am under no obligation to sign this form, however if I do not sign and return this form, the Ombudsman will not be authorized to make inquiries on my behalf. I may cancel this authorization at any time by sending written notice of cancellation signed by me or my legally authorized representative to the Mental Health Ombudsman at the address listed above.