## 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	n-e-mail address		
Work Phone	Home Phone	Cell Ph	one
Address			
City		State	Zip
A brief explanation of the second secon	of the difficulty you are having:		
a. Agency	(ies) that may share information from the Omb	oudsman:	
b. Please	identify the type of information that may be sha	ared with the Ombudsman:	
	disclosed from records whose confidentiality is al or other information is NOT sufficient for this		general authorization
2. What do you consid	ler to be a fair resolution to your concern/issue	?	
3. On the back, provid	e any additional information you think would be	e helpful.	
PLEASE ATTACH ANY DOCUMENTS RELATED TO YOUR CONCERN.			
	ent and authorize the Office of the Mental Heal encies I have indicated above and to use this i		
Signature			Date
Description of your auth	ority to sign for the person requesting assistar	nce, if applicable	

This authorization to obtain and use confidential information expires <u>on the earliest of</u>. (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.