2755 Colonial Drive
P.O. Box 5539
Helena, MT 59604

PATIENT BILL OF RIGHTS

I HEREBY CONFIRM I HAVE BEEN INFORMED OF PATIENT BILL OF RIGHTS AND RESPONSIBILITIES AND THE DISABILITY RIGHTS MONTANA NOTICE AND HAVE RECEIVED A COPY OF THIS DOCUMENT.

_____

Parent/Guardian Signature Date

_____

Patient Signature Date

_____

Witness Signature Date

Patient Name: _____

Patient Rights Form/W.FILE; Revised 6/10