STATE OF MONTANA
DEPARTMENT OF ADMINISTRATION

HCBD HEALTH CARE & BENEFITS DIVISION

STEVE BULLOCK, GOVERNOR

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Helena, MT 59620-0130

Authorization for the Release of Confidential Information

Name: _____

Social Security Number: _____

Date of birth: _____

1. I authorize the use or disclosure of the above named individual's health information as described below. The Health Care and Benefits Division, State of Montana is authorized to make the disclosure.

2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate) (circle the applicable type):

_X_____ Enrollment
_X_____ Payment
_X_____ Claims Adjudication
_X_____ Case or medical management records including:
_X_____ Problem(s) [list] from (date) _____ to (date) _____
_X_____ Medication(s) [list] from (date) _____ to (date) _____
_X_____ Most recent history and physical
_X_____ Most recent discharge summary
_X_____ Laboratory results from (date) _____ to (date) _____
_X_____ X-ray and imaging reports from (date) _____ to (date) _____
_X_____ Consultation reports from (doctor's names) _____
_X____ Enter record from (date) _____ to (date) _____

Other
_____
_____

3. This information may be disclosed to and used by the following individual or organization:

_____.

4. This information shall be used to _____.

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Care and Benefits Division, State of Montana. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If no expiration date, event, or condition is specified, this authorization will expire in twelve (12) months.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Care and Benefits Division at 1-800-287-8266.

Signature of member or legal representative:_____

Date: _____

If signed by legal representative, authority to act for member:

_____

Signature of witness:_____

Date: _____