AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Section A. Member Information

Name	Date of Birth	Member ID

Mailing address for records

City	State	Zip

Phone Number	Alternate Phone Number

This Authorization is provided in accordance with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards") issued under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA").

I, _____, am a member in the State of Montana Benefit Plan and hereby authorize the use or disclosure of my protected health information as described in this Authorization.

1. Specific person(s)/organization authorized to provide the information.

State of Montana Benefit Plan, P.O. Box 200130, Helena, MT 59620-0130.

2. Specific person(s)/organization authorized to receive and use the information. To authorize a person, you must include the name, date of birth, and relationship to the individual.

3. Description of the information to be used and/or disclosed, including (if applicable), time periods for the information. Note: *If left blank, any and all information will be disclosed to the person or organization designated above in Question 2.*

4. Describe the purpose for which the health information described above will be used.

Section B. Signature Required.

I, _____, hereby understand the following:

a) Right to Revoke: I understand that I have the right to revoke this Authorization at any time by notifying the Health Care and Benefits Division in writing, at the appropriate address below. I understand that the revocation is only effective after it is received and logged by the Health Care and Benefits Division. I understand that I cannot revoke this authorization to the extent that action has been taken in reliance of this authorization (for example, any use or disclosure made prior to the revocation under this Authorization will not be affected by the revocation).

b) I understand that after the information that is the subject of this Authorization is used or disclosed, the Privacy Standards may not protect it and the recipient may re-disclose it.

c) I understand that this Authorization is not required for the State of Montana Benefit Plan to use or disclose this information for purposes of treatment, payment or health care operations, or if the use or disclosure is otherwise permitted by the Privacy Standards, and that any revocation of this Authorization will have no effect on such uses or disclosures.

d) I understand that I am entitled to receive a copy of this Authorization.

e) I understand this Authorization will expire in one (1) year from the date of signature, unless revoked pursuant to sub-section (a) above.

_____ _____

Date Individual

If signed by someone other than the member in Section A, please check the appropriate box below. You must provide proof of your authority to receive this health information.

☐ Parent of minor child ☐ Legal guardian

☐ Power of attorney for healthcare ☐ Personal representative (deceased member)

Section C. Finalize and submit.

1. Form must be fully completed and signed.
2. Submit to the following:
   a. Email to: BenefitsQuestions@mt.gov
   b. Fax to: (406) 444-0080
   c. Mail to: Health Care and Benefits Division, Department of Administration PO Box 200130
      Helena, MT 59620-0130