AUTHORIZATION
For the Use and Disclosure of Protected Health Information

Montana Department of Public Health and Human Services (DPHHS)
PO Box 4210, Helena, MT 59604-4210

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) prohibits your Protected Health Information (PHI) from being shared without your permission except in certain situations. By signing this form, you are giving us permission to share the health care information you indicate below. PHI disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy law. DPHHS may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization. You may cancel this authorization in writing at any time, including by signing the "Authorization Revocation" below and returning it to DPHHS.

Individual or Entity you are authorizing to receive your Protected Health Information:

_____

The type of information to be disclosed is: _____

_____

The reason for this disclosure of my Protected Health Information is: _____

_____

The expiration date for this authorization is: _____
Or when a particular event takes place (List event) _____

_____

I understand that if I do not state an expiration date or event, that this authorization will expire thirty months (two and one half years from the date of my signature).

Recipient Name: _____

Program (Medicaid, etc.) ID Number (if applicable): _____

Signature: _____ Date: _____

AUTHORIZATION REVOCATION:

I no longer want my Protected Health Information shared with the individual/entity above.

Signature _____ Date _____