AUTHORIZATION FOR RELEASE OF INFORMATION

INDIVIDUAL: Name and information of person whose Protected Health Information is being disclosed:

1	A Ya VYf#9bfc`IYY`First Name	MI:	Member/Enrollee Last Name:	Date of Birth:	Subscriber ID #:

Mailing Address:	City:	State:	ZIP:

PURPOSE AND AUTHORIZATION

☐ Legal ☐ Insurance ☐ Personal ☐ Continuation of Care ☐ Assisting in Medical Care
☐ Other: (Specify) ____

I request and authorize Montana Unified School Trust/Montana School Services Foundation (Company) to disclose my Protected Health Information as described below. **I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.**

Name:			
Mailing Address:	**City:**	**State:**	**ZIP:**
Phone Number:	**Fax Number:**		

TYPES OF INFORMATION TO BE USED OR DISCLOSED: Based on the box(es) I have checked below, the Company may release all diagnostic, procedural, claim or other related information and records. Specific authorization is required for Sensitive Protected Health Information. This authorization CANNOT be used to disclose psychotherapy notes.

Release of Sensitive Protected Health Information: ☐**YES** ☐**NO**

You **must** check "Yes" or "No" if you authorize the release of medical information, test results, records or communications specific to any of the following:

☐ Human Immunodeficiency Virus (HIV) or HIV/Acquired Immune Deficiency Syndrome (AIDS)

☐ Sexually transmitted or "communicable" diseases (including hepatitis, as well as venereal diseases)

☐ Drug, alcohol and/or substance abuse

☐ Mental health/psychiatric disorders or developmental disabilities (including mental retardation or similar disabilities, for example, those attributable to cerebral palsy, autism or neurological dysfunctions)

☐ Genetic Testing

RELEASE OF PROTECTED INFORMATION		Dates of Service: From:	To:
☐ Health Plan Benefit Information	Includes information contained in your benefit booklet (i.e., copayments, coinsurance, eligibility and other benefit information).		
☐ Claims Information	Includes information related to payment of your claims for service you received, including pertinent information located on a claim form (i.e., billed amount, general procedure descriptions, claim payment or denial reasons, etc.).		
☐ Service Determination Information	Includes any information related to pre-service, concurrent and post-service decisions.		
☐ Premium			
☐ Services (from Provider or Supplier)	Provider Name:		
☐ Other (list):	Specify other information that is not listed in one of the categories above.		

MUST
MONTANA UNIFIED SCHOOL TRUST

AUTHORIZATION FOR RELEASE OF INFORMATION

HOW INFORMATION WILL BE USED:

Disclosure Format (paper by US Mail is default if not marked):

☐ US Mail ☐ Fax ☐ E-mail ☐ Electronic Format (please indicate preference):

☐ CD ☐ Flash Drive ☐ Other:____________________

EXPIRATION AND REVOCATION:

This authorization will expire on (choose one):

☐ 24 months from the date it is signed ☐ Other:______________________

(insert date or event, not to exceed 24 months from the date it is signed)

Revocation: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. **I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.**

SIGNATURE OF PATIENT OR PATIENTS REPRESENTATIVE (this document must be signed by the individual, parent of minor child or the individual's personal representative):

I understand that this authorization is voluntary and that the health plan cannot condition my eligibility for benefits, treatment, enrollment or payment of claims on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

____

SIGNATURE DATE

____

PRINT NAME

*If not the member/enrollee, I am the:

☐ Parent ☐ Legal Guardian ☐ Holder of a Power of Attorney ☐ Personal Representative ☐ Executor or Administrator

If you are the legal guardian or holder of a power of attorney for the member/enrollee, attach legal documentation.

BEFORE RETURNING THIS FORM YOU SHOULD KEEP A COPY FOR YOUR RECORDS BY EITHER:

(1) MAKING A PHOTOCOPY OF THIS SIGNED AUTHORIZATION; OR
(2) COMPLETING THE DUPLICATE AUTHORIZATION FORM YOU RECEIVED OR PRINTED.

Mail or fax the completed signed authorization to:

Montana School Services Foundation
PO Box 4579
Helena, MT 59604
HIPAA Fax: 406.444.5161