AUTHORIZATION
For the Use and Disclosure of Protected Health Information

Montana Department of Public Health and Human Services
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 information you indicate below. *This does not keep the information from being shared with more people once it leaves our office*. You may cancel this Authorization at any time by signing the AUTHORIZATION REVOCATION below and returning it to the Department of Public Health and Human Services (DPHHS).

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

_____

I give permission to the Department of Public Health and Human Services to share the Protected Health Information indicated below with the Individual or Entity listed above:

- ☐ All information
- ☐ Information from a specific time period (specify dates):

  From _____ To _____
- ☐ All information relating to a certain event or injury *(Example: left knee injury from December 2009, specify event and dates.)*

  Event_____ Date: _____
- ☐ Other (specify) _____

Client Name: _____Program ID Number (if applicable): _____

Signature: _____ Date: _____

EXPIRATION: no later than thirty (30) months from the date of signature, or according to an expiration date or event you specify below, whichever is earlier:

_____

AUTHORIZATION REVOCATION:

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

Signature _____Date _____

Date: 08/2018

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