Missoula County
Employee Benefits Plan
200 W. Broadway
Missoula MT 59802-4292
(406)523-4876 Fax (406)523-4731

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

<u>Complete all sections, date and sign</u>

I. I, ____ of

____
(Address) (City, State, Zip) (Phone)

Hereby voluntarily authorize the disclosure of information from my heath record.

II. Purpose or need for this disclosure is:

- ☐ Personal / Family (specify) ____
- ☐ Attorney
- ☐ Further Medical Care
- ☐ Other (specify) ____

III. Information to be disclosed from my health record:

- ☐ Only information related to (specify) ____________________________________
- ☐ Only the period of events from ________________ to ________________________
- ☐ Other (specify)____
- ☐ Entire record

Some information is covered by additional protection and requires additional authorization. To authorize release or discussion of the following, the person named above must initial and date each item.

Initial	Date		From	To
_____	___________	Alcohol or drug abuse treatment/referral	____________________	____________________
_____	___________	Mental health treatment	____________________	____________________
_____	___________	HIV status or treatment	____________________	____________________

IV. I understand I may revoke this authorization in writing submitted at any time to the Missoula County Employee Benefits Plan. If this authorization has not been revoked, it will terminate one year from the date of my signature.

____
(specify new date)

V. I understand Missoula County Employee Benefits will not condition treatment or eligibility for care on my providing this authorization except where specifically excluded by the Plan Document.

____ ________________________
Signature **Date**