MISSOULA COUNTY EMPLOYEE BENEFITS PLAN

Mailing Address: 200 West Broadway
Physical Address: 223 West Alder Street
Missoula, MT 59802-4292

P: 406.258.4876 | F: 406.258.4731
E: benefits@missoulacounty.us

Missoula COUNTY

Protected Health Information, ("PHI") is information, including demographic information, that identifies an individual and relates to the physical or mental health of an individual, health care that the individual has received, or the payment for health care provided to that individual. PHI is protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Missoula County Employee Benefits Plan ("MCEBP") may use your PHI for purposes of making or obtaining payment for your care and conducting health care operations. MCEBP has established a policy to guard against unnecessary disclosure of your PHI. Please refer to page 1 of the MCEBP document to review MCEBP HIPAA Notice. The MCEBP document can be found at www.mcebp.com.

Except as stated in the HIPAA notice, MCEBP will not disclose your PHI without your written authorization. If you authorize MCEBP to use or disclose your PHI, you may revoke that authorization in writing at any time.

MCEBP cannot release PHI for someone over the age of 18 to a parent or spouse without authorization. Enclosed is a form authorizing MCEBP to use or disclose your PHI to designated recipients. If you wish to allow MCEBP to disclose your PHI to a party, such as your spouse or parent, please fill out the form and return it to the Risk and Benefits Office at the address below.

Missoula County Employee Benefits Plan
200 West Broadway
Missoula, MT 59802

Sincerely,

Missoula County Employee Benefits Plan

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Complete all sections, date and sign.

I. I, _____ of

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

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

II.Name of the person/agency to whom you give authority to receive information:

Name_____ Phone_____

_____
(Address) (City, State, Zip)

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 three years 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**