AUTHORIZATION
For the Use and Disclosure of Health Information

Montana Department of Public Health and Human Services
P.O. Box 202960, Helena, MT 59620-2690

Federal law 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*. This authorization will only last until the date you specify, but not longer than thirty months.

If you want to cancel this Authorization at any time, you should sign the AUTHORIZATION REVOCATION below and return it to the Department of Public Health and Human Services (DPHHS).

Name of Individual or Entity you are authorizing to receive your PHI:

_____

Signature of Authorized Representative: _____ Date: _____

Relationship of Authorized Representative _____

I give permission to the Department of Public Health and Human Services to share the PHI 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 *(printed)* Signature

AUTHORIZATION REVOCATION:

I no longer want my PHI shared.

Signature _____ **Date** _____

Date: 08/2013

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