

# AUTHORIZATION For the Use and Disclosure of Health Information

Montana Department of Public Health and Human Services  
P.O. Box 202960, Helena, MT 59620-2960

Federal law prohibits your Protected Health Information ("PHI") 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").

Date: \_\_\_\_\_

Individual or Entity: \_\_\_\_\_

I give permission to the Department of Public Health and Human Services to share the health information checked 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 2000* (specify event and dates):

Event \_\_\_\_\_

Date of event \_\_\_\_\_

Other (specify): \_\_\_\_\_

Printed Name: \_\_\_\_\_ Signature \_\_\_\_\_

Signature of Authorized Representative \_\_\_\_\_ Date \_\_\_\_\_

Relationship of Authorized Representative \_\_\_\_\_

### AUTHORIZATION REVOCATION

I no longer want my information shared.

Signature \_\_\_\_\_

Date \_\_\_\_\_