Montana Health Justice Partnership

AUTHORIZATION FOR USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all authorizations

I _____ _____authorize my health care provider, Northwest Community Health Center to disclose the specific Information about me described below, for the Purpose(s) described below to:

Montana Legal Services Association
616 Helena Ave Ste. 100
Helena, MT 59601
Fax: (406) 442-9817

Information To Be Used Or Disclosed:

- My name, address, phone, date of birth, last four digits of my social security number, a copy of my Montana Health Justice Partnership screening form, a copy of this authorization form, and diagnostic documentation from my encounter with my healthcare provider on _____, 201____.

Purpose(s) For The Use Or Disclosure:

The purpose(s) for which I authorize the release: ❑ Referral to the Montana Health Justice Partnership

I understand the following conditions:

1. I may refuse to sign this authorization and that this authorization is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing and doing so will stop future use or disclosure of my protected health information, but I understand my health care provider can act on this Authorization until either I revoke my authority in writing or until the expiration date contained in this Authorization occurs.
4. If I want to revoke this Authorization, I will send my written notice of revocation to the following address:

   _____
   _____
   _____
5. I understand that I may see and obtain a copy of the information described on this form or a copy of this form, if I ask for it.
6. I understand Northwest Community Health Center cannot control any further disclosure of my protected health information by those who received it after it is disclosed as allowed by this Authorization, and that my protected health information may not be subject to continued protection under federal law once it is received by the recipient.

Unless I indicate an earlier time, this Authorization expires twelve (12) months from the date I sign:_____.

Section B: Signature

I have read the above and authorize the disclosure of the protected health information as stated.

_____ _____

Signature of Patient/Guardian/Patient Representative Date

_____

Print Name of Patient/Patient Representative

_____

Relationship or scope of your legal authority to act on the patient's behalf