Montana Health Justice Partnership
Authorization to Release Case-Related Information

I, _____, voluntarily authorize the Montana Legal Services Association (MLSA), to use or disclose specific information including my identifying information and the outcome of my case to my healthcare provider, Northwest Community Health Center. I understand I am not required to sign this release in order to receive services from MLSA.

The MLSA may also orally discuss my situation freely with employees of MLSA. Facsimile, photostatic, carbon or other copy of this authorization shall be treated as an original.

Signature for Legal Authorization:

_____ _____

Signature of Patient/Guardian/Patient Representative Date