Authorization for Disclosure of Individual Health Information and Claim Information

Claimant Whose Information is to be Disclosed (please print):

Claimant Name: _____
Street Address: _____ Daytime Telephone: _____
City: _____ State: _____ ZIP Code: _____

Person(s) or Entity(ies) to Whom Information May Be Disclosed (please print):

Name(s): _____
Street Address: _____ Daytime Telephone: _____
City: _____ State: _____ ZIP Code: _____

Information to be Disclosed:

□ Treatment Records/All Medical Records
□ Insurance, Claim and Billing Information:
□ Other: _____
(Specify other information authorized for disclosure if not listed in categories above)

Actions Authorized to be Performed by the Above Named Individual:

□ Contact staff of the Montana Medical Legal Panel to discuss my claim (for scheduling, procedure and information requests)
□ Staff of the Montana Medical Legal Panel to contact above named individual to discuss my claim (for scheduling, procedure and information requests)
□ Other: _____
(Specify other actions you authorize the above named person to perform on your behalf)

Reason for disclosure (check one):

□ At the request of the authorized individual or entity
□ Other reason for disclosure (other than "at the request of the authorized individual or entity") (describe):
_____

Length of Time for Which This Authorization is Valid:

This authorization is valid up to 24 months (or a shorter period of time if so indicated) or for a particular event that has occurred, as stated in the authorization. If you are making this authorization for an extended period, the authorization will have to be renewed after its expiration. This authorization will remain in effect until (check one):

□ 24 months from the date of signature of this authorization
□ Until _____, but no longer than 24 months from the date of signature
(Month/Day/Year)
□ Until all information relating to a certain event or injury has been provided (e.g., "Back injury from April 2009" or "formal research") (Specify event and approximate date of event):
_____

I understand this authorization is not valid without the required signature. I understand that I may refuse to sign this authorization. I understand that the recipient of this information may possibly re-disclose the information to others without my knowledge or authorization, in which event the privacy law may no longer protect my information. I understand I have the right to revoke this authorization at any time in writing, except to the extent that information has already been provided. To revoke this authorization, write to Montana Medical Legal Panel at 2021 Eleventh Ave., Ste 1, Helena< MT 59601 or call Montana Medical Legal Panel at (406) 443-1110.

_____ _____ _____
Print Full Name Signature Date

AUTHORITY TO SIGN ON BEHALF OF CLAIMANT:
Please check applicable box if signing on behalf of claimant and provide a copy of authorizing document for items marked below with an asterisk (*).

□Parent of Minor Child □Legal Guardian* □Power of Attorney* □Other Personal Representative Designation*