MMIA
MONTANA MUNICIPAL INTERLOCAL AUTHORITY
PO Box 6669 ▪ Helena, MT 59604-6669
Toll Free: (800) 635-3089 ▪ Tel: (406) 443-0907 ▪ Fax: (406) 449-7440

AUTHORIZATION FOR RELEASE OF INFORMATION

I_____ hereby authorize the use or disclosure of my individually identifiable health information as described below.

Patients Name: _____ ID Number: _____

Montana Municipal Interlocal Authority
Post Office Box 6669
Helena MT 59604 Fax: 406-449-7440

Specific description of information (including date(s)):

_____
_____
_____
_____

I further understand and agree:

1. This authorization will expire upon the termination of my participation in my employer's group health plan.
2. I may revoke this authorization at any time by notifying the providing person/ organization in writing (although it won't have any affect an any actions they took before the received the revocation)
3. I may see and copy the information described on this form if I ask for it.
4. I am not required to sign this form to enroll in, or receive my health care benefits under, the group health plan.
5. The information that is used or disclosed under this authorization may be redisclosed by the receiving entities, but only for the specific purposes authorized.

If I am signing this Authorization as a patient's personal representative, I certify that I have the authority to act on behalf of the patient and that the information provided below to verify my identity is correct.

_____ _____

Signature of patient or patient's representative **Date**

Name of patient's representative, if applicable: _____

Representative's Date of Birth: _____

Relationship to the patient: _____