MOUNTAIN HEALTH CO-OP

Form CO016
Rev. 11/27/17

Authorization for Disclosure of Protected Health Information

Member Information

Member Name_____ Member ID Number_____

Date of Birth_____ Phone Number_____

Full Member Address _____

SSN _____ Providing your SSN is voluntary, but helpful to accurately identify your medical records; supplying the last four digits is also an option. _____

Information to be Disclosed

I request and authorize Montana Health Co-Op/Mountain Health Co-Op to DISCLOSE my protected health information.

Please select what you wish to disclose. ☐ All/Full Record ☐ Other/Please Detail Below

_____

Recipient Information

I authorize the following person(s) or organization to access my member information:

Name_____ Relationship _____

Please indicate the purpose of the disclosure of your member records:

_____

This authorization expires (select one)

☐ One time disclosure ☐ One Year Other / Please indicate:

_____

If applicable, I understand that based on the information I have designated above; the disclosure Mountain Health Co-Op makes pursuant to this authorization may include information regarding my participation in a substance abuse treatment program.

I understand that if the authorized recipient of this information is not a health care provider or health plan covered by federal privacy regulations, the information he/she receives will no longer be protected by these regulations, and the recipient may re-disclose the information.

However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that Mountain Health Co-Op will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I may inspect or copy any information used or disclosed under this authorization. I understand that I may revoke this authorization in writing at any time by sending a written revocation of authorization to: Mountain Health Co-Op by mailing to Mountain Health Co-Op, PO Box 5358, Helena, MT 59604 or faxing it to 1-406-447-5799. I understand that my revocation is not effective to the extent that action has been taken in reliance on this authorization.

_____ _____

Signature Date

If Applicable, Printed Name of Personal Representative _____

Description of Personal Representative Authority:

◯ Parent Power of Attorney (attach documentation)

◯ Other (attach documentation)

Return completed form by mailing it to Mountain Health Co-Op, PO Box 5358, Helena, MT 59604 or faxing it to 1-406-447-5799.