Montana Health Cooperative dba
MOUNTAIN HEALTH CO-OP
MEDICARE SUPPLEMENT
ADMINISTRATIVE OFFICE
P.O. Box 2209
Duncan, OK 73534-2209
Telephone: 1-800-366-8354

Health Information Authorization

- Type or print clearly and use blue or black ink.
- This is a HIPAA Compliant Authorization.

Agent: Have applicant complete and sign copy to submit with application.
Applicant keeps one copy.

Applicant Declarations

Please read these statements carefully

I authorize the use and disclosure of health information about me as described below.

Health Information to be Used or Disclosed: I understand this authorization applies to information about: my past, present, or future physical or mental health or condition and may include facts about my other insurance coverage, hazardous activities, finances, vocation, and other personal traits. This information may come from my medical records including, but not limited to prescription history, diagnoses and treatment for illnesses, HIV or AIDS, sexually transmitted diseases and conditions including, but not limited to, mental illness and the use of drugs, alcohol and tobacco, but excluding psychotherapy notes and information about previously administered tests for t-cell counts or other information not permitted to be disclosed under applicable law.

Who May Request or Use Information: This information may be disclosed to and used and or disclosed by: Mountain Health Co-Op; its insurance support organizations; its affiliates and reinsurers; care providers, treatment facilities, insurers, pharmacy benefit managers, the Medical Information Bureau (MIB) and consumer reporting agencies.

Who is Authorized to Disclose Information: All of the following persons or entities are authorized to disclose health information or records about me: care providers or evaluators, physicians, chiropractors, physical therapists, psychologists, drug, alcohol, and mental health counselors, pharmacy benefit managers and other health professionals; treatment facilities including hospitals, clinics, drug or alcohol treatment or consultation facilities, nursing homes, mental health facilities, ambulatory care centers and other medical or medically related facilities.

In addition, I authorize Mountain Health Co-Op to disclose collected information to other insurers, reinsurers and the Medical Information Bureau (MIB). The Medical Information Bureau (MIB) and consumer reporting agencies may only disclose information as set forth in a contract with a member company or organization.

Purpose: This health information may be used or disclosed to: evaluate and underwrite my insurance application; determine premium amounts, adjudicate claims and to support the operations of health plans.

Statements of Understanding: I understand that: (1) I will receive a copy of this Authorization and that a copy of it is as valid as the original; (2) this Authorization will be valid for 30 months from the date signed; (3) I may revoke this Authorization by sending a written request for revocation to Mountain Health Co-Op at the Medicare Supplement Administrative Office identified above; (4) if I do not sign this Authorization, or revoke it as provided for above, my application may be declined; (5) If I revoke this Authorization, my revocation is not effective for any information that might have been used or disclosed in reliance on this Authorization; and (6) some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws. I further understand that such information may be redisclosed only in accordance with applicable laws or regulations.

Primary applicant please fill in this information

Signature of applicant Date

X _____

Printed name of applicant

X _____

City State Zip

If this Authorization is signed by a legal representative of the applicant, please identify the representative's relationship to the applicant: _____