AUTHORIZATION
To Access Claims Based Medical History

Federal law says that we cannot share your health information without your permission except in certain situations. If you sign this form, you are giving us permission to share the health information you indicate below. *This does not keep the information from being shared with more people once it leaves our office*. This authorization will only last until the date you specify, but not longer than one year.
If you decide later that you do not want us to share your information any more, you can sign the REVOCATION SECTION at the end of this form and return it to us.

Date: _____

Person or Group Needing the Health Information: _____

I give permission to _____ to access my Claims Based Medical History on the Montana Access to Health Web Portal .

The entity listed above is granted permission to access either Basic or Expanded Medical History, as indicated below:

- ❑ Basic Medical History
- ❑ Expanded Medical History, including Mental Health, Family Planning, STD and Abortion related treatments

Chemical Dependency and HIV/AIDS related treatments are NEVER displayed.

Printed Name: _____

Signature_____

Signature of Authorized Representative _____Date_____

Relationship of Authorized Representative_____

REVOCATION SECTION

I no longer want my information shared.

Signature_____ **Date**_____