

Information Release Authorization Form

Name (Last, First, M/I)	Home Telephone Number
Address	City/State/Zip

Authorization

I, _____, do hereby authorize the Insure Montana program to release protected information to the following individual: _____.

This information is to be disclosed for the purpose of: _____

Information To Be Released

The following information may be released to the authorized individual listed above:

(Select all that apply)

- Demographic Information (address, telephone number, etc.)
- Sensitive Personal Identifier Information (Date of Birth, Social Security number, etc.)
- Protected Health Information
- Personal Financial and Public Assistance Information
- Plan Information (Insurance Premium Amount, Premium Assistance Payment Amount, Plan Benefits, etc.)

****Only personal information of the individual completing this form will be released. Separate authorization must be obtained from a household member whose personal information is sought.**

Release Expiration Date

This authorization expires 24 months following the signature date unless you indicate otherwise below:

- This authorization shall expire on ___/___/___

Note: This authorization can be revoked at any time by contacting the Insure Montana by telephone or in writing.

Signature

_____	_____	___/___/___
Print Full Name	Signature	Date

If **legal guardian** of insured, indicate relationship: _____