



**BlueCross BlueShield
of Montana**

An Independent Licensee of the Blue Cross and Blue Shield Association
®Registered Marks of the Blue Cross and Blue Shield Association,
an Association of Independent Blue Cross and Blue Shield Plans

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
FOR UNDERWRITING PURPOSES**

I, _____ (Name of Signatory), hereby authorize the care provider(s) listed below to release information about the person, as identified below, to Blue Cross and Blue Shield of Montana, Inc. (BCBSMT), 560 North Park Avenue, Helena, Montana 59601. Information to be released may be generated by the provider(s) or by another source. I further authorize that copies of this authorization form shall be valid as executed originals. Copies of this form may be provided to all providers listed below. Additional authorization forms are available upon request.

Please list the names and addresses of all care providers seen in the past five years:

Name	Address

Information identifying person whose medical information is authorized to be disclosed to BCBSMT:

Name: _____ Date of Birth: _____
 Address: _____ Telephone Number: _____
 _____ Social Security Number: _____

Specific information to be disclosed, if marked:

_____ Information regarding _____ (Name of Person to Whom Information Pertains) medical history.

_____ Medical records related to any care, service, and/or product provided by a health care provider including but not limited to medical or psychological diagnosis, treatment, or advice provided to _____ (Name of Person to Whom Information Pertains).

_____ Other (specify) _____

Length of time for which authorization is valid:

Under applicable law, this authorization is valid up to 24 months (or a shorter period of time if so indicated) or for a particular event that has occurred, as stated in the authorization. If you are making this authorization for an extended period, the authorization will have to be renewed after its expiration. This authorization will remain in effect until:

- 24 months from the date of signature of this authorization; **or**
- Until _____, but no longer than 24 months from the date of signature.
(Month/Day/Year)

- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect the ability to obtain treatment, payment, or eligibility for benefits with BCBSMT. However, there may be consequences with the intended recipient of this information.
- I understand this authorization is not valid without the required signature.
- I understand I have the right to revoke this authorization at any time in writing, except to the extent that Blue Cross and Blue Shield of Montana has already provided the information. To revoke this authorization, contact Customer Service at 1-800-447-7828.
- I understand that the recipient of this information may possibly disclose the information to others without my knowledge or authorization therefore; the privacy law may no longer protect my information.

_____ Print Full Name _____ Signature _____ Date _____

Relationship/Authority: Please check one. Include documentation with this form for items marked with an asterisk (*) below.

- Member Power of Attorney* Other Personal Representative Designation*
- Parent of Minor Child Legal Guardian*