MONTANA UNIFIED SCHOOL TRUST

Note: A separate form must be completed for each person age 18 or older.

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH AND CLAIM INFORMATION

_____ has requested health and/or claims information concerning claims submitted and paid for the covered person(s) shown below. Because laws exist to protect the privacy of confidential health and claims information, we need valid authorization from you, the Covered Person, to disclose this information to the requesting party. Please sign the following form in the presence of a Notary Public and return the completed form to First Choice Health—MUST, P.O. Box 12569, Seattle, WA, 98111-4659.

Name of School District: _____ Group Number: _____

Name of Covered Person: _____ SS# of Covered Person: _____

Name of Dependent(s): _____ Birth Date: _____ (If applicable)

Name of Dependent(s): _____ Birth Date: _____ (If applicable)

As the Covered Person under the above-named group health plan, I hereby authorize MUST to release the following confidential health and claims related information:

_____

_____

_____

This information may be disclosed to: _____, at the following address,

_____, whose relationship to the Covered Person is:

_____, for the following purpose(s):

- _____ To determine eligibility for benefits, enrollment in a group health plan, or for underwriting determinations;
- _____ For payment of provider claims;
- _____ Other: _____

I agree to indemnify and hold MUST harmless for confidential health and/or claims information released to the named person(s) based upon this authorization.

This authorization will remain valid until the Covered Person is no longer covered under the above-named group health plan, for two years or until the following date: _____, whichever occurs earlier.

I understand I may revoke this authorization at any time, upon written notice to First Choice Health—MUST, P.O. Box 12569, Seattle, WA, 98111-4659., unless either: 1) MUST has already disclosed my confidential information in reliance upon this authorization; or 2) this authorization was a condition of my enrollment in the group health plan.

I understand that MUST may not condition treatment, payment of claims, enrollment in a group health plan or eligibility for benefits upon this authorization, UNLESS this authorization is expressly for the purposes of determining eligibility for benefits, enrollment, or for underwriting or risk rating determinations.

I understand that any confidential health and/or claims information disclosed to the requesting party in accordance with this Authorization may be re-disclosed by the requesting party and at that point, would no longer be protected by this Authorization.

_____ _____

Signature of Covered Person Date

STATE OF _____ COUNTY OF _____

Signed and acknowledged by _____ who provided proof of identification and who personally appeared before me, a Notary Public, this _____ day of _____, 20____.

(Seal)

_____

Signature of Notary Public

My commission expires _____.