9/2020

Missoula City-County Health Department
Communicable Disease Office
301 W Alder Street| Missoula, MT 59802-4123
PHONE | 406.258.3896
FAX | 406.258.3610

AUTHORIZATION FOR THE DISCLOSURE OF COVID-19-RELATED HEALTH INFORMATION

If you sign this form, you are giving us permission to share the health information you indicate below. This does not prevent the information from being re-shared by the recipients.

Client Name: Date of Birth:

Phone: Other Name(s) Used/Maiden Name:

I consent to and authorize MCCHD to disclose COVID-19-related health information regarding me or a minor of whom I am the parent or legal guardian to the following:

#1. Individual/Organization to receive information:

Phone:

Fax:

Address:

City:

State: Zip:

#2. Individual/Organization to receive information:

Phone:

Fax:

Address:

City:

State: Zip:

I understand that the purpose is for conducting contact tracing and/or reducing the spread of covid-19.

Unless otherwise revoked, this authorization will expire one month after it is signed. By signing this authorization, I acknowledge that:

- I have the right to revoke this authorization at any time. Revocation must be done in writing. I understand that I cannot revoke an authorization for information that has already been released in response to this authorization.
- This authorization is voluntary. I can refuse to sign this authorization. I need not sign this authorization to receive treatment, payment for services, enrollment or eligibility for benefits.
- I may inspect or copy this authorization provided in 45 CFR 164.524. I understand that any disclosure of information under this authorization carries with it the potential for an unauthorized re-disclosure by the recipient and, after it is disclosed, the information may not be protected by state or federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Missoula City-County Health Department Health Services Division Director.

If you don't have access to a printer or electronic signature, you may type your name here as a signature:

Client/Authorized Representative* Signature: Date:

***Parent, Legal Guardian, or Legal Representative. Supporting legal documentation must accompany this form when services are requested by the client's Legal Guardian or Legal Representative.**

Please Print Your Name:
Relationship to Client: