AUTHORIZATION AND RELEASE FOR USES AND DISCLOSURES
OF PROTECTED HEALTH INFORMATION (PHI) AND RELEASE OF RIGHTS

Section A: This section must be completed for all Authorizations

I authorize my primary care clinic (PCC), _____, and the Montana Primary Care Association (MPCA) to use or disclose the specific Information about me described below, for the Purpose(s) described below.

Patient name:	Birth Date:	Phone Number:
Patient Address:	E-mail address:	

Information To Be Used Or Disclosed

- My name and any photograph or video in which I may appear.
- **Protected health information** about me (as defined in the Federal Health Insurance Portability and Accountability Act (HIPAA)). This may include information about my access to care, the care I have received, my clinical outcomes, my health conditions, my income, and my insurance status.
- Any other information I may share during an interview.

Purpose(s) For The Use Or Disclosure

I acknowledge and agree that the PCC or MPCA may use and disclose all or any part of the Information described above, including **protected health information**:

- for marketing, educational, policy advocacy, and public relations purposes; and
- in press releases, print and online publications, public service announcements, and other materials ("Materials"), any or all of which may be printed, transmitted, broadcast, posted online, or otherwise published in any type of media.

Release of Rights

I hereby grant to MPCA any and all rights I may have with regard to any Materials, including any copyright in them.

On behalf of myself and any family member about whom I may share information, and to the fullest extent permitted by law, I waive all rights and release any claim based upon or relating to the use or disclosure of the Information as set forth above. This waiver of rights and release of claims shall include, but not necessarily be limited to:

- Claims against the PCC, MPCA, MPCA's members, and any of their agents, employees, directors, officers, successors and assigns;
- Claims for invasion of any right to privacy, violation of any right of publicity, violation of any law regarding **protected health information**, or any similar matter; and
- Claims that may have been unknown or unforeseen on the date I signed this authorization.

I understand that:

1. I may refuse to sign this authorization and that this authorization is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any Materials published or actions taken by the PCC or MPCA before the organization received the revocation. (To revoke this authorization, please contact MPCA at (406) 442-2750 or contact your PCC directly.)
4. Unless I choose to revoke this authorization, it remains in effect and will not expire until the PCC or MPCA decide to no longer publish or use any Information.
5. Once released, my information may no longer be protected by federal privacy regulations and may be re-disclosed.
6. I understand that I may see and obtain a copy of the information described on this form or a copy of this form, if I ask for it.
7. This authorization is given without any promise that I will receive compensation.

Section B: Signature

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient Representative:	Date:
Print Name of Patient/Patient Representative	Relationship or scope of your legal authority to act on the patient's behalf: