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. This includes 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. 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: ________________________________ Social Security Number: ______________________

____

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.

- I understand that this authorization is required in order to enable BCBSMT to make eligibility or enrollment determinations relating to me and/or my minor children or for BCBSMT's underwriting or risk rating determinations.
- I understand that I may refuse to sign this authorization and that my refusal to sign can affect the ability to obtain coverage with BCBSMT.
- 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 been provided the information. To revoke this authorization, contact Customer Service at 1-800-447-7828.
- I understand that all information received by BCBSMT may be subject to redisclosure or used only as allowed by law.

______________________________ ______________________________ ______________

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*