Missoula Housing AUTHORITY
Your way home.

1235 34TH ST. • MISSOULA, MT 59801
(406) 549-4113 • FAX: (406) 549-6406 TTY 771
MISSOULAHOUSING.ORG
EQUAL HOUSING OPPORTUNITY • EQUAL OPPORTUNITY EMPLOYER

Medical Release of Information

Complete ONLY if Head of Household, Co-Head, or Spouse are elderly (62+) and/or disabled AND you are claiming out-of-pocket medical expenses.

TO THE AGENCY RELEASING INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by Federal and State Law. Federal Regulations (42 C.F.R. Part 2) prohibits you from making any further disclosure without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for release of medical or other information is NOT sufficient for this purpose.

I _____ born on _____ /_____ /_____ authorize Missoula Housing Authority to obtain and release information about me from and to the following:

I _____ born on _____ /_____ /_____ authorize Missoula Housing Authority to obtain and release information about me from and to the following:

PLEASE INIITIAL ALL THAT APPLY

___ Western Montana Clinic
___ Community Medical Center Physician/Hospital
___ St. Patrick's Physician/Hospital
___ Providence Health Systems Physician/Hospital
___ Inland Imaging
___ MT Neurological Associates
___ MT Neurobehavioral Specialists
___ Rocky Mountain ENT
___ Rocky Mountain Eye Center
___ Rocky Mountain Optical
___ Grant Creek Family Medical
___ Case Management_____
___ Other_____
___ Other_____

___ Partnership Health Center
___ Walgreens; **Location**_____
___ Safeway Pharmacy; **Location** _____
___ Osco Pharmacy; **Location**_____
___ CVS Pharmacy
___ Savmor Drug
___ Big Sky Denture
___ Missoula Bone and Joint
___ Norco
___ Harrington Medical Supply
___ CBM
___Other_____
___Other_____
___Other_____

I VOLUNTARILY ALLOW THE ABOVE NAMED PARTIES TO EXCHANGE INFORMATION. I UNDERSTAND THAT THIS INFORMATION WILL NOT BE FORWARDED TO ANYONE OTHER THAN THE PARTIES LISTED ABOVE WITHOUT MY WRITTEN PERMISSION. I UNDERSTAND THAT I CAN REVOKE THIS RELEASE AT ANY TIME.

THIS CONSENT FORM EXPIRES 15 MONTHS AFTER SIGNED

_____ _____
Signature Date

_____ _____
Signature Date