Authorization for the Use and Disclosure of Protected Health Information (PHI)
(45 CFR 164.508)

Please keep a copy of this form for your records.

Section 1. Member Information

Member Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Member ID Number: _____

Section 2. I hereby authorize the use or disclosure of my protected health information (PHI) as described below. I understand PHI can include the following types of information, and authorize its disclosure: medical records; substance abuse care; vision care; reproductive care; mental health; communicable disease; pharmacy; HIV/AIDS; dental records; and psychotherapy.

This protected health information may be disclosed:

_____

_____

The information is being released for the following purpose(s):

_____

_____

The Managed Care Plan is authorized to disclose the above-named member's protected health information to the person(s)/organization(s) listed in Section 3 below.

Section 3: Name of person(s)/organization(s) authorized to receive protected health information:

_____

_____

Section 4: Terms and Conditions

By signing below, I hereby authorize the disclosure of my Protected Health Information by the Managed Care Plan as described herein. I understand that:

- This authorization expires on the following date or event* _____, or upon revocation by me in writing, whichever occurs first. *If no expiration date or event is specified, this authorization will expire 12 months from the date signed below.

- I understand that I have the right to revoke or cancel this authorization at any time by providing notice in writing to the Managed Care Plan's Privacy Official.
- If I revoke or cancel this authorization, it is not effective for the use or for the disclosure of my information that has already occurred.
- I understand that if the person or entity receiving the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above could be re-disclosed by such person or entity and will likely no longer be protected by federal privacy regulations.
- I understand that this authorization is voluntary and that I may refuse to sign it. The provision of treatment, payment, enrollment in the health plan, or eligibility for benefits cannot be conditioned on the signing of this authorization, unless the authorization is necessary for determining eligibility for the program or enrollment in the program.
- I understand that I have a right to receive a copy of this authorization, if requested by me.
- I understand that in the event my records contain psychotherapy notes, a separate authorization may be required for the release of any psychotherapy notes.
- I understand that this authorization permits the use and/or disclosure of information related to HIV testing or the treatment of AIDS or AIDS related conditions, drug or alcohol abuse, psychiatric conditions (excluding psychotherapy notes) unless specifically excluded above.

Section 5: Signature

By signing this document, I confirm that I have had full opportunity to read and consider the contents of this authorization, and confirm that the contents are consistent with my direction to the Managed Care Plan.

_____	_____
Signature of Member or Member's Personal Representative	Date
_____	_____
Printed Name of Member or Member's Personal Representative	Relationship to Member or Representative's Authority to act for the Member, if applicable

Return completed form to Managed Care Plan's Privacy Contact.