Authorization for the Use and Disclosure of Protected Health Information

Name of Member: _____ Member ID#: _____

Member Address: _____ Date of Birth: _____

City/State/Zip: _____ Telephone #: _____

I hereby authorize the use or disclosure of my protected health information (PHI) as described below.

1. Persons or organizations authorized to use or disclose the protected health information:

Molina Healthcare

2. Name(s) and address(es) of persons or organizations authorized to receive or use the protected health information: (please print)

3. Specific description of the protected health information that may be used or disclosed:

All of my health information including, but not limited to, my medical records, health care claims, authorizations, medications and provider information.

4. **Release Requiring Specific Approval:** I know my records may contain PHI about testing, diagnosis or treatment for HIV/AIDS, for any other Sexually Transmitted Diseases (STDs), for Alcohol and Drug Abuse, for Chemical Dependency, and/or for Mental Health. I will allow Molina Healthcare of Washington, Inc. to disclose and/or re-disclose any and all such information, except for the information I initial below.

   I don't want my health care information about testing, diagnosis or treatment for the following shared:

   ___ HIV/AIDS; ___ Other STDs; ___ Alcohol & Drug Abuse/Chemical Dependency; ___ Mental Health

5. The protected health information will be used or disclosed for:

To help me with my health care, payment for health care or coordination of my health care.

6. I understand the following:

   a) I may revoke this authorization at any time. I can do this by telling Molina Healthcare in writing or verbally. This right does not apply to actions already taken by Molina because of this authorization.

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Molina Authorization for the Use and Disclosure of PHI – Washington- English
MRC Part #16-2146 Approvals: MHW—2/19/16 HCA—3/23/16 (2016-047)

b) I know this authorization is voluntary and I may refuse to sign. If I refuse to sign this, it will not affect my:
   - Treatment
   - Payment or
   - Enrollment or eligibility for my benefits

c) I know the PHI I authorize a person or entity to receive may be re-disclosed. I know that state and federal law may no longer protect this PHI. Please see "Notice of Recipients of Alcohol and Drug Abuse Information" below.

d) I have a right to receive a copy of this authorization.

7. This authorization expires 90 days from the date of your signature unless otherwise specified below.

   This authorization expires [on / upon] _____

Signature of Member or Member's Personal Representative	Date

Personal Representative's Name, if applicable (please print): _____

Relationship to Member: ☐ Parent ☐ Legal Guardian* ☐ Holder of Power of Attorney *

☐ Other Please Describe: _____

Description of Personal Representative's authority to act for the member (please print):

* Please attach legal documentation if you are the legal guardian or Holder of Power of Attorney for Healthcare Decisions.

A copy of this signed form will be provided to the Member, if the authorization was sought by Molina Healthcare.

NOTICE TO RECIPIENTS OF ALCOHOL OR DRUG ABUSE INFORMATION

This information has been disclosed to you from records protected by the Federal confidentiality rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.