



# 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 stated below.**

1. Name of persons/organizations authorized to make the requested use or disclosure of protected health information:

\_\_\_\_\_  
Molina Healthcare  
\_\_\_\_\_

2. Name and address of persons or organizations authorized to receive or use the protected health information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Description of the protected health information that may be used/disclosed\*:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\* I know this may include PHI related to:

- Sexually transmitted diseases;
- HIV/AIDS;
- Other communicable diseases;
- Behavioral or mental health diseases; and
- Referral and/or treatment for alcohol and drug abuse (as permitted under 42 CFR Part 2)

4. The protected health information will be used/disclosed for the following purpose(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. I know that:

- a. This authorization is voluntary.
- b. I do not have to sign this form. I can refuse it.

- c. My refusal to sign will not affect any of the following:  
     My eligibility for benefits or enrollment;  
     Payment for services; or  
     My ability to be treated.
- d. I have a right to get a copy of this form. I must ask for a copy.
- e. I may revoke this authorization at any time. To do so I have to let Molina know in writing. Such revocation will not apply to actions that Molina has taken in reliance on this authorization.
- f. The protected health information I authorize a person or entity to get may no longer be protected by federal law and regulations.

6. This authorization expires on the following date or event\* \_\_\_\_\_

*\*If not stated above, this authorization will expire 12 months from the date signed below.*

\_\_\_\_\_  
 Signature of Member or Member's Personal Representative

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Printed Name of Member

**Personal Representative's Name, if applicable (please print):** \_\_\_\_\_

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

Other Please Describe: \_\_\_\_\_

**\* 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 given to the member, if Molina sought it.**