AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Member Name:________________________________ Member ID #:__________________________________

Member Address:______________________________ Date of Birth:_________________________________

City/State/Zip:________________________________ Telephone #:__________________________________

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

1. Name and address of Molina Healthcare entity authorized to make the requested use or disclosure of protected health information:

   Molina Healthcare of Florida
   8300 NW 33rd St, Ste 400
   Doral, FL 33122

2. Name of persons/organizations authorized to receive the protected health information:

   ____
   ____
   ____

3. Specific description of protected health information that may be used/disclosed *(for example, "All of my claims paid by Molina from May 1, 2009 to April 30, 2010")*:

   ____
   ____
   ____

4. The protected health information will be used/disclosed for the following purpose(s) *(for example, "For my legal representation in a lawsuit")*:

   ____
   ____
   ____

5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment.

6. I understand that I have a right to receive a copy of this authorization, if requested by me.

7. I understand that I may revoke this authorization at any time by notifying Molina Healthcare in writing, except to the extent that Molina Healthcare has taken any action in reliance on this authorization.

8. I understand that the information I authorize a person or entity to receive may be no longer protected by federal law and regulations.

9. This authorization expires on the following date or event* : ________________________________
If no expiration date or event is specified 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 or Member's Personal Representative, if applicable	Relationship to Member or Personal Representative's Authority to act for the Member, if applicable

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