Non-Disclosure Directive

This form directs Molina Healthcare of Washington, Inc. to communicate with you about your personal health information at the address you select.

1. Member Information (* = Required)

First Name* _____ Last Name* _____ Date of Birth* _____

Member ID _____ Subscriber Number _____

Address* _____ City* _____ State* _____ Zip Code* _____

Phone Number: _____

2. **Do Not Disclose This Type of Information.** Check all that apply:

____ General Health information

____ Reproductive health (including abortion)

____ Mental or Behavioral Health or Psychiatric information

____ Alcohol or Chemical Dependency

____ Sexually Transmitted Disease, including HIV/AIDS

____ Substance Use Disorder Treatment

____ Genetic Information

3. Alternate Address

_____ Use the address in section 1
_____ Use the address below until I revoke or terminate this Directive (Address is required if this option is selected)

Address _____ City _____ State _____ Zip Code _____

4. Please Read This Before You Sign and Send

This Non-Disclosure Directive does not apply to your healthcare provider. You must give them separate, specific instruction about what healthcare information they may share, and with whom. This request stays in effect until you notify us in writing that it is terminated or revoked. Your health plan may have already shared health information before it received this request, and that disclosure cannot be changed. Your health plan and its representatives are not required to comply with this request if a court order or court document prohibits us from following your directive. We will act upon your request within 3 business days of receiving it from you. You may also call us at (888) 858 – 3492 to provide us with this direction.

5. Signature (Required)

Print Name _____ Signature _____ Date Signed _____

Mail to: Molina Healthcare
Attn: Service Fulfillment
200 Oceangate Ste 100
Long Beach CA 90802
Email: NonDisclosureDirective@Molinahealthcare.com
Fax: (844) 834-2155