AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Member Name:			**Member ID #:**
Member Address:			**Date of Birth:**
City:	**State:**	**Zip:**	**Phone #:**

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

1. Name and address of Molina Healthcare (Molina) entity authorized to use or disclose the PHI:
   - *Molina Healthcare of New Mexico, PO Box 3887, Albuquerque, NM 87190*

2. Name and address of person or organization authorized to receive or use the PHI:

3. Description of the PHI that may be used and/or disclosed*:

*I know that 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 PHI will be used and/or 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 to.
   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 PHI I authorize a person or entity to get may no longer be protected by federal law and regulations.

6. This authorization will expire on this date or event* : _____
**If not stated above, this authorization will expire 12 months from the date below.*

_____ _____

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: _____

*** 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.

Contact Information

If you have any questions, please contact the following:

Molina Healthcare of New Mexico
Attn: Compliance Department
P.O. Box 3887
Albuquerque, NM 87190
(505) 348-0464 or Toll-Free: (800) 377-9594