# 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*:

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

* 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):

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

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.**