Authorization to Use or Disclose Protected Health Information (PHI)

1. Member Information

I, _____ (Member Name) _____ (Member Identification Number-optional) _____ (Subscriber Identification Number) , ___/___/___ (Date of Birth - MM/DD/YYYY)

_____ (Address) _____ (City) _____ (State) _____ (Zip Code)

hereby give permission to: _____ (Name of person/class of persons)

2. Recipient Information

To *(please check one or both as appropriate)*

☐ **DISCLOSE TO** and / or

☐ **OBTAIN** information from: _____ (Name of Recipient [person/class of persons])

_____ (Recipient's Address - optional) _____ (City - optional) _____ (State- optional) _____ (Zip Code - optional)

_____ (Phone Number - optional) _____ (Fax Number - optional)

3. Protected Health Information To Be Used or Disclosed

Purpose of use or disclosure: _____

The following information (specify): _____

4. Expiration of Authorization, which provides consent to use or disclosure PHI (check one):

❑ This date (no more than 1 year from today): _____

❑ When this happens: _____

5. Your Rights

- ❖ You can end this authorization (permission to use or disclose information) any time by writing to {Name or Department/CMC address}. If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- ❖ Magellan does not condition treatment, payment, enrollment, or eligibility on your signing this form.
- ❖ You do not have to agree to this request to use or disclose your information.
- ❖ You have a right to a copy of this signed authorization. Please keep a copy for your records.

6. Re-disclosure By Recipient

Except as described below, information that is disclosed as a result of this Authorization Form may be subject to re-disclosure by the recipient and no longer protected by law. Magellan has to follow laws that protect your health information, but not all persons or organizations have to follow these laws.

If you have questions about anything on this form, call to speak to a Magellan Representative: { }.

7. Signature

OR

_____ (Signature of member) _____ (Date) _____ (Authorized representative if required) _____ (Date)

If signed by authorized representative, describe authority to act for member: _____

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Authorization to Use or Disclose Protected Health Information (PHI)

INSTRUCTIONS

Authorization to Use or Disclose Protected Health Information (PHI)
This form gives Magellan permission to use or disclose some of your health information. If Magellan is making the request for information, some of the information on the form will be completed for you. If you request that Magellan use or disclose the information, you will need to fill in the information. It is important that you fill out this form completely and correctly. If you have a question about anything on this form, call the number in the signature section and a Customer Service Representative will direct your call to someone who can answer your questions.

1. Member Information
Please write the name, address, and date of birth of the person who is giving permission to use or disclose PHI. While the member's identification number is optional, Magellan requires the **Subscriber Identification Number**.

In the field "hereby give permission to:" enter the name of the person, entity, or class of persons that are allowed to make the use or disclosure of your PHI. **In most cases you will simply write "Magellan Health Services."**

2. Recipient Information
Please enter the name and address of who will be receiving or obtaining your health information. While the address and phone number is optional, providing the address and phone number greatly assists Magellan in identifying the individual or individuals that receive or disclose your protected health information.

The recipient identified in this field would typically be the name of a family member, attorney, or other party who would normally not be permitted access to your confidential medical record.

3. Protected Health Information To Be Used or Disclosed
Please provide the reason for the use or disclosure of your PHI. If you have requested that Magellan disclose this information to someone, you don't have to put the reason and can write, "at my request."

Next, we ask that you specify the information pertaining to this request. If Magellan is making this request, we will fill in the information we would like to use or disclose. If you are requesting that Magellan disclose PHI about you, complete this section as specifically as possible. Some examples of information you might include are:

- Dates of service or treatment
- Services authorized
- Names of providers seen

If you are unsure, contact a Customer Service Representative at the number listed near the bottom of the Authorization Form.

4. Expiration of Authorization
Permission for information to be used or disclosed is for a set time period. Magellan needs to know when this permission ends. Indicate when the permission ends by filling in an end date or an end event. If you fill in an event it should relate to the purpose of the disclosure. For example, you could state that the permission ends when you complete a certain program.

5. Your Rights
If you later decide you want to stop giving Magellan permission to use or disclose your PHI, you can do so by writing to us at the address on the form. This will not include information that has already been disclosed, based on your prior permission.

If Magellan is making this request to use or disclose your PHI, you do not have to agree to it. Just do not fill out or sign this form. Magellan cannot stop you from receiving treatment, payment, being enrolled, or your eligibility for benefits if you do not agree to sign this Authorization Form. You have a right to a copy of this request to use or disclose your health information. Please keep a copy for your records.

6. Re-disclosure by Recipient
If you are requesting that Magellan disclose your information to someone else, you should know that not everybody has to follow laws to protect your information. Once your information is disclosed, it may not be afforded the same protection as Magellan provides health information.

7. Signature
Please sign and date the form. If you are a representative acting for someone please send documentation that tells Magellan you have the authority to sign this form in place of that person.

If you are sending/faxing the signed form to Magellan, please keep a copy for your records. If you are signing the form at a Magellan office, you will be provided a copy.

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.