

INSTRUCTIONS

Authorization to use or Disclose Protected Health Information (PHI)

This form gives Magellan Health Services (MHS) permission to use or disclose protected health information to another person or entity. It is important that all sections are completed and the data is correct or the form WILL NOT be valid. If you have any questions about anything on this form, call the number listed on Section 7 - "Important Rights and Other Required Statements You Should Know".

Section 1. Who is the Patient

Please write the name, address, and date of birth of the patient who is giving Magellan permission to use or disclose his or her protected health information. Also write the ID number and insurance company name of the subscriber (sometimes called the policyholder) from your ID card for identification purposes.

In the field "I hereby authorize the use or disclosure of protected health information about the individual named above" please identify if it is the actual patient or a representative completing the form by checking the appropriate box.

Section 2. Who Will Be Disclosing Information About the Individual

This section identifies the person or entity that is given permission to disclose the patient's protected health information.

Section 3. Who Will Be Receiving Information About the Individual

This section identifies the person or entity that will be receiving or obtaining your protected health information. This information will assist in limiting the disclosure of your protected health information to only the person or entity you indicate.

Section 4. What Information about the Individual Will Be Disclosed

Specify exactly what kind of information is going to be disclosed. Please be as specific as possible, because a very general description could result in more information being disclosed than was intended. Some examples of the type of information you might include are:

- Dates of services
- Services authorized
- Names of providers seen

Section 5. What is the Purpose of the Disclosure

Please provide the reason the protected health information of the patient is being disclosed. If the disclosure of this information is initiated by the patient and they would prefer not to provide a statement of the purpose, it is sufficient to indicate "At the request of the individual".

Section 6. What is the Expiration Date or Event

This authorization form must expire within 1 year. By choosing an expiration date or event, this limits the span of time during which the protected health information can be disclosed. Please check the appropriate box and identify the expiration date or event. If choosing an expiration event it should relate to the purpose of the disclosure and it must occur within 1 year. If choosing an expiration date it must be a valid date and must not be more than one year from the date the form was completed. If no expiration date or event is selected, this form WILL NOT be valid and no disclosure of protected health information can occur.

Section 7. Important Rights and Other Required Statements You Should Know

Revocation. If you later decide you want to stop the disclosure of protected health information described in this form, you can do so by writing to us at the address located in this section. This would not include information that has already been disclosed based on this form.

Re-disclosure by Recipient: Not all persons or entities have to follow certain federal and state laws designed to protect the privacy and confidentiality of protected health information. Once protected health information is disclosed, it may not be afforded these protections by the person or entity receiving it.

Section 8. Signature of the Individual

This signature block is for the patient. Please sign and date the form. If not completed the form is NOT valid and no disclosure of protected health information can occur.

Section 9. Signature of Personal Representative (if applicable)

This signature block is for the personal representative who is acting on the patient's behalf. Please provide documentation validating your legal stature.

Example: ■ Health Care Power of Attorney ■ Parental Agreement (divorce decree)

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.