Authorization for the Use or Disclosure of Protected Health Information

Member Name: _____ SSN: _____
Address: _____ City/State/Zip: _____
Member ID: _____ Date of Birth: _____

As described in our privacy notice, Managed Health Services (MHS) is required by law to obtain your authorization for any use or disclosure of your health records for purposes other than your treatment, the payment for healthcare services provided to you, or the healthcare operations of MHS. In our privacy notice, we provided you with information about how MHS can use or disclose your health records. You have a right to review and receive a copy of our privacy notice before signing this authorization. You can read a copy of our privacy notice in the back of your Member Handbook.

1. I, _____ authorize the use and disclosure of my health information as described below:

This authorization applies to the following information: _____

_____

_____

_____

_____

_____

2. I authorize the following person (or class of persons) to receive my health information:

Name: _____
Title: _____ Phone: _____
Address: _____ City/State/Zip: _____

Information to be disclosed (check all that apply):

☐ Medical Records ☐ Treatment Records ☐ Diagnostic Records
☐ Other: _____

3. We are requesting this authorization in order to use or disclose your health information for the following purposes _____

_____

_____

☐ At the request of the individual.

4. This authorization expires (date or event): _____
Do not say “never expires”. If you want this to last a long time, please pick a day a long time from now.

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Members with speech or hearing disabilities call 1-800-743-3333 for TTY/TDD.

You may request to inspect or copy the information that MHS intends to disclose. You may refuse to sign this authorization. MHS will not condition treatment, payment, enrollment or eligibility for benefits on your refusing to provide this authorization. Once release of this health information is made to the above named person or persons, your health information may be subject to redisclosure by that person or persons. If you have authorized the disclosure of health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected.

You may revoke this authorization at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to MHS. You may deliver your revocation by any means you choose (e.g. personally or by mail), but it will be effective only when we actually receive it. Your revocation will not be effective to the extent that we or others have acted in reliance upon this authorization.

If you are requesting information for yourself or a third party, MHS may assess appropriate and reasonable fees for the copying of such information. Such fees will comply with all state and federal laws.

AUTHORIZATION

I, _____ have had full opportunity to read and consider that the contents are consistent with my direction to MHS. I understand that, by signing this form, I am confirming my authorization that MHS may use and/or disclose to persons and/or organizations named in this form the health information described in this form.

_____ _____

Signature of Member or Legal Representative Date

_____

Print Name

_____

Description of Personal Representative's Authority

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

MHS Fax Number: 1-866-912-1629

For MHS Use Only

Name: _____

Title: _____

Signature: _____

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MHS is your choice for better healthcare. You or someone in your family is an MHS member and that is why we send you information. MHS handles your medical insurance through your enrollment with Hoosier Healthwise, the Healthy Indiana Plan or Hoosier Care Connect. If you need this or any other information in another language or format, or have any problems reading or understanding this information, please call MHS Member Services Monday through Friday from 8 a.m. to 8 p.m. at 1-877-647-4848. Learn more at mhsindiana.com.