## AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Member Name: _____ Member ID #: _____

Member Address: _____ Date of Birth: _____

City, State Zip: _____ Telephone #: _____

**I hereby authorize the use and disclosure of my protected health information as described below.**

1. Name of persons/organizations authorized to make the requested use or disclosure of protected health information:

_____

_____

_____

2. Name of persons/organizations authorized to receive the protected health information:

_____

_____

_____

3. Specific description of protected health information that may be used/disclosed:

_____

_____

_____

4. The protected health information will be used/disclosed for the following purpose(s):

_____

_____

_____

5. The person/organization authorized to use/disclose the protected health information will receive compensation for doing so. Yes_____ No_____

6. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided under numbers 7 and 8 on this form.

7. Molina Healthcare may condition the provision of research related treatment on my provision of an authorization for the use or disclosure of PHI for such research.

8. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, Molina Healthcare reserves the right to deny that health care.

9. I understand that I have a right to receive a copy of this authorization, if requested by me.

10. I understand that I may revoke this authorization at any time by notifying Molina Healthcare in writing, except to the extent that:

    a) action has been taken in reliance on this authorization; or
    b) if this authorization is obtained as a condition of obtaining health care coverage, other law provides the health plan with the right to contest a claim under the benefits or coverage under the plan.

11. I understand that the information I authorize a person or entity to receive may be no longer protected by federal law and regulations.

12. This authorization expires on the following date or event*: _____

    * *If no expiration date or event is specified 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 or Member's Personal Representative (if applicable) | Relationship to Member or Personal Representative's Authority to act for the Member (if applicable) |

**A copy of this signed form will be provided to the Member if the authorization was sought by Molina Healthcare.**