MAGELLAN HEALTH SERVICES
Getting Better All the Time

Authorization to Use or Disclose Protected Health Information (PHI)

Section 1. Who is the Patient?

Last Name	First Name	Middle Initial

Subscriber Number From ID Card	Insurance Company Name	Date of Birth (MM/DD/YYYY)	Phone Number

Street Address	City	State	Zip Code

I hereby authorize the use or disclosure of protected health information about the individual named above.

I am: ☐ the individual named above (complete Section 8 below to sign this form)
☐ a personal representative because the patient is a minor, incapacitated, or deceased (complete Section 9 below)

Section 2. Who Will Be Disclosing Information About the Individual?

The following person(s) or entity may use or disclose the information:

Name (a person, a class of persons like "doctors who treated me in August 2003," or an organization)	Phone Number (if known)
Magellan Behavioral Health, a subsidiary of Magellan Health Services	

Street Address (if known)	City, State and Zip Code (if known)

Section 3. Who Will Be Receiving Information About the Individual?

The information may be disclosed to:

Name (a person, a class of persons like "family members residing with me", or an organization)	Phone Number (if known)

Street Address (if known)	City, State and Zip Code (if known)

Section 4. What Information About the Individual Will Be Disclosed?

Please specify the type of behavioral health and/or substance abuse services information to be disclosed, including any relevant dates. _____

Section 5. What is the Purpose of the Disclosure?

Please give the reason the information is being requested or disclosed.

_____

Section 6. What is the Expiration Date or Event?

This authorization must expire within 1 year, on either a specific date or upon a specific event. Please choose either:

- ☐ the following expiration date (no more than 1 year from today): _____
- ☐ the following specific event (needs to happen within 1 year): _____

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

- ❖ You can revoke this authorization at any time by writing to [Magellan, Privacy Officer, PO Box 4910, Columbia, MD 21046 or fax to 1-443-896-1386]. If you revoke this authorization, it will not apply to information that has already been used or disclosed.
- ❖ The information disclosed based on this authorization may be redisclosed by the recipient and may no longer be protected by federal or state privacy laws. Not all persons or entities have to follow these laws.
- ❖ You do not need to sign this form in order to obtain enrollment, eligibility, payment, or treatment for services.
- ❖ This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure.
- ❖ You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask us for a copy at any time by writing to [Magellan Health Services, Attention: Privacy Officer, PO Box 4910, Columbia, MD 21046].
- ❖ If you have any questions about anything on this form, or how to fill it out, we can help. Please call [number on your insurance card].

Section 8. Signature of the Individual

Signature_____ Date (required) _____

Section 9. Signature of Personal Representative (if applicable)

Signature_____ Date (required) _____

Please describe your relationship to the individual and/or your legal authority to act on behalf of the individual in making decisions related to healthcare. You may be asked to provide us with the relevant legal document giving you this authority.

Relationship to the individual (required): _____

NOTICE TO RECIPIENT OF INFORMATION

Maryland law prohibits any person from re-disclosing medical information without authorization from the member. 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.

*Magellan Behavioral Health is an affiliate of Magellan Health Services.