Authorization to Use or Disclose Medical Information

Please see instructions on Page 2

<table>
<tr><td rowspan="3">**Member Information**</td><td colspan="5">Member Name</td><td colspan="2">Previous last name (if any)</td></tr>
<tr><td colspan="6">Street Address</td><td>Date of Birth</td></tr>
<tr><td>City</td><td>State</td><td>ZIP code</td><td colspan="3">Member ID#:</td><td>Phone number</td></tr>
<tr><td rowspan="2">**Release Information *From***</td><td colspan="4">Health Plan / Hospital / Clinic / Physician</td><td>Phone number</td><td colspan="2">Fax number</td></tr>
<tr><td colspan="4">Street Address</td><td>City</td><td>State</td><td>Zip code</td></tr>
<tr><td rowspan="2">**Release Information *To***</td><td colspan="4">Family / Facility / Physician / Health Plan / Attorney</td><td>Phone number</td><td colspan="2">Fax number</td></tr>
<tr><td colspan="4">Street Address</td><td>City</td><td>State</td><td>Zip Code</td></tr>
<tr><td>**Information to be Released**</td><td colspan="7">❑ Entire Patient File
❑ Case Management and/or Medical Authorization
❑ Claims & Billing Information
❑ FSA / HRA Information
❑ Grievance & Appeals Information
❑ Membership Information
❑ Other, please specify:</td></tr>
<tr><td>**Special Permissions**</td><td colspan="7">❑ Developmental Disabilities
❑ Genetic Testing Information
❑ HIV-Related Information (AIDS)
❑ Mental Health Information
❑ Psychotherapy Notes*
❑ Sexually Transmitted Diseases
❑ Substance Use Disorders (alcohol and/or drug abuse)</td></tr>
<tr><td>**Limitations of Release**</td><td colspan="7">Do <u>NOT</u> release the following:
(leave blank if no special limitations)</td></tr>
<tr><td>**Purpose**</td><td colspan="7">❑ Grievance & Appeals
❑ Discussion / Care Coordination
❑ Further Medical Care
❑ Legal Use
❑ Payment / Billing
❑ Personal Use
❑ Treatment Planning
❑ Transfer of Care
❑ Other, please indicate:</td></tr>
<tr><td>**Release Method**</td><td>❑ Mail</td><td>❑ Fax</td><td>❑ Phone</td><td colspan="3">❑ Email
➢ Email Address:</td><td>❑ Pick Up
➢ Date:</td></tr>
<tr><td rowspan="3">**Authorization and Revocation**</td><td colspan="7">• I voluntarily authorize the disclosure of the protected health information identified above.
• I understand that I may refuse to sign this authorization. Refusal to sign will not affect my ability to obtain treatment or payment for services, nor will it impact my eligibility for benefits.
• I understand that I may revoke this authorization at any time, except to the extent disclosure of records has already occurred in reliance on it. I understand my revocation must be in writing and will not take effect until received. *Send your written request to: Privacy Officer, 1605 Associates Dr., Suite 101, Dubuque, IA 52002.*
• I understand that if the person or organization that receives my protected health information is not a health plan or health care provider, the released information may no longer be protected by privacy regulations.
• I understand that this authorization is effective immediately upon signature and will remain in effect for 24 months from the date of signature, unless I specify an earlier end date here:__________________</td></tr>
<tr><td colspan="6">Signature of Member or Member's Representative</td><td>Relationship to Member</td></tr>
<tr><td colspan="6">Printed Name</td><td>Date</td></tr>
</table>

Instructions to complete the Authorization to Use or Disclose Medical Information Form.

Print legibly and include all pertinent information.

1. **Member Information.** Complete the entire section. The Member ID# is located on your insurance card.
2. **Release Information *From*.**
   - This authorization will be sent or provided to the facility listed in this section.
   - If requesting that Health Choices release protected health information, see address below.
   - If requesting that the protected health information be released to Health Choices from another organization, include as much information as possible.
3. **Release Information *To*.** Provide pertinent details for the recipient of your protected health information. If the information is to be released to a family member or other authorized representative, please specify in this section.
4. **Information to be Released.**
   - In this section, check all the boxes that apply to your specific need.
   - Release of "FSA/HRA information" would be information pertaining to a Flexible Spending Account or a Health Reimbursement Arrangement.
   - If you check the "other" box, please describe in detail the information necessary to meet your specific needs. If you are requesting information pertaining to a specific date of service or a specific medical condition or diagnosis, please use this box to identify those specific needs as well.
5. **Special Permissions.**
   - In accordance with federal and/or state laws, special permission is required for disclosure if the release pertains to any of the categories listed within this section. Identify and authorize the release of this information by selecting the boxes that apply to your specific need. **Note that if authorization is for the release of psychotherapy notes, this authorization cannot be combined with another release.*
   - If authorization is for the disclosure of mental health information, you may inspect the disclosed information at any time.
   - Certain laws may prohibit re-disclosure of protected health information, such as state laws pertaining to mental health information and developmental disabilities.
   - Federal regulation at 42 CFR Part 2 prohibits unauthorized disclosure of substance abuse records. Federal rules prohibit any further disclosure of this information unless further disclosure of this information 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 rule restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
6. **Limitations of Release.** If you would like to place any limitations on this authorization for disclosure of protected health information, specify your limitations here. Please leave blank if there are no special limitations on the information for disclosure.
7. **Purpose.** Indicate the purpose for which the information is required.
8. **Release method.** Tell us how you would like your information delivered.
   - Mail option. Protected health information will be mailed to the address listed under "Release Information *To*".
   - Fax option. Protected health information will be faxed to the fax number listed under "Release Information *To*".
   - Phone option. Protected health information selected under "Information to be Released" will be released over the phone to the individual listed under "Release Information *To*".
   - Email option. Protected health information will be sent in a secured email to the email address indicated in this field.
   - Pick up option.
     - Please indicate the date on which you will pick up the protected health information.
     - A photo I.D. will be required to receive the protected health information.
     - If someone other than the member will pick up the protected health information, please indicate on this form, the person's name.
9. **Authorization and Revocation.** Sign and Date the authorization form.
   - You are entitled to receive a copy of this authorization form.
   - Verification of the authority of a personal representative, such as a copy of a power of attorney or health care power of attorney, will be required (unless it already has been provided).
10. **Return to:**

    Medical Associates Health Plan, Inc.
    Member Services Department
    1605 Associates Drive, Suite 101
    Dubuque, IA 52002

    Fax: (563) 584-4760
    Email: live360healthplan@mahealthcare.com