Authorization to Use and Disclose Health Information

Notice to Member:

- Completing this form will allow Meridian Medicaid Plan to (i) use your health information for a particular purpose, and/or (ii) share your health information with the individual or entity that you identify on this form.

- You do not have to give permission to use or share your health information. Your services and benefits with Meridian will not change if you do not submit this form.

- If you want to cancel this authorization form, send us a written request to revoke it at the address on the bottom of this page. A revocation form can be provided to you by calling Member Services at 866-606-3700 (TTY: 711).

- Meridian cannot promise that the person or group you allow us to share your health information with will not share it with someone else.

- Keep a copy of all completed forms that you send to us. We can send you copies if you need them.

If you need help, contact Member Services at 866-606-3700 (TTY: 711). Fill in all the information on this form. When finished, mail the form and any supporting documentation to:

Meridian Medicaid Plan
ATTN: Compliance Department
1333 Burr Ridge Parkway Ste 100
Burr Ridge, IL 60527
privacy.il@mhplan.com

meridian

PLEASE READ THE INSTRUCTIONS CAREFULLY AND COMPLETE THE FORM BELOW. INCOMPLETE FORMS CANNOT BE ACCEPTED.

1 **MEMBER INFORMATION:**

Member Name *(print)*: _____

Member Date of Birth: _____ Member ID Number: _____

2 **I GIVE Meridian Medicaid Plan PERMISSION TO USE MY HEALTH INFORMATION FOR THE PURPOSE IDENTIFIED OR TO SHARE MY HEALTH INFORMATION WITH THE PERSON OR GROUP NAMED BELOW. THE PURPOSE OF THE AUTHORIZATION IS** *(check one option below)***:**

☐ to allow Meridian to help me with my benefits and services, **OR**

☐ to permit Meridian to use or share my health information for _____

3 **PERSON OR GROUP TO RECEIVE INFORMATION** *(add more persons or groups on last page)***:**

Name (person or group): _____

Address: _____

City: _____ State: _____ Zip:_____ Phone: (____) _____

4 **I AUTHORIZE Meridian Medicaid Plan TO USE OR SHARE THE FOLLOWING HEALTH INFORMATION** *(NOTE: Select the first statement to release ALL health information or select the second statement to release only SOME health information.* ***Both CANNOT be selected.****)*

☐ **All of my health information INCLUDING:**

Genetic information, services or test results; HIV/AIDS data and records; mental health data and records (but not psychotherapy notes); prescription drug/medication data and records; and drug and alcohol data and records (please specify any substance use disorder information that may be disclosed);

OR

☐ **All of my health information EXCEPT** *(check only the boxes below that apply)***:**

- ☐ Genetic information, services, or tests
- ☐ AIDS or HIV data and records
- ☐ Drug and alcohol data and records
- ☐ Mental health data and records (but not psychotherapy notes)
- ☐ Prescription drug/medication data and records
- ☐ Other: _____

5 **THIS AUTHORIZATION ENDS ON THIS DATE/EVENT:** _____

Date this authorization ends unless cancelled. If this field is blank, the authorization expires one year from the date of the signature below.

6 **MEMBER OR LEGAL REPRESENTATIVE SIGNATURE:**

_____

DATE: _____

IF LEGAL REPRESENTATIVE - Relationship to Member: _____

If you are the Member's legal or personal representative, ***you must send us copies of relevant forms****, such as power of attorney or order of guardianship.*

MAIL COMPLETED AUTHORIZATION FORM AND ANY SUPPORTING DOCUMENTATION TO
Meridian Medicaid Plan, ATTN: COMPLIANCE DEPARTMENT
1333 Burr Ridge Parkway Ste 100 Burr Ridge IL 60527
privacy.il@mhplan.com

Meridian complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **866-606-3700** (TTY: **711**).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **866-606-3700** (TTY: **711**).

ADDITIONAL INDIVIDUAL PERSON(S) OR GROUP(S) TO RECEIVE INFORMATION:

NOTE: If you are consenting to disclose any substance use disorder records to a recipient that is neither a third party payor nor a health care provider, facility, or program where you receive services from a treating provider, such as a health insurance exchange or a research institution (hereafter, "recipient entity"), you must specify the name of an individual with whom or the entity at which you receive services from a treating provider at that recipient entity, or simply state that your substance use disorder records may be disclosed to your current and future treating providers at that recipient entity.

Name (individual or entity): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: ( ) -

Name (individual or entity): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: ( ) -

Address: _____

Name (individual or entity): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: ( ) -

Name (individual or entity): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: ( ) -

Name (individual or entity): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: ( ) -

Name (individual or entity): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: ( ) -

Name (individual or entity): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: ( ) -

Name (individual or entity): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: ( )-