Authorization to Use and Disclose Health Information

Use this form to request authorization for the release of Protected Health Information (PHI), including patient profile or prescription records to your authorized representative named in Section 2 below.

1. Member Information (please provide current information)

_____

Last Name First Name Middle Initial

_____

Mailing Street Address

_____

City State Zip Code

_____

Member ID Number

_____

Date of Birth (mm/dd/yyyy) Phone Number with Area Code

2. Authorized Representative's Information

I authorize MaxCare to use and disclose my PHI to the person named below. I understand that there are certain parties that must protect the privacy of my PHI. These are health care providers and other parties who are required to do so under federal or related state laws. If my authorized representative is not a health care provider or another party required to protect my PHI, it could be discussed and/or released by my authorized representative without my permission.

_____

Name Phone Number with Area Code

_____

Mailing Street Address

_____

City State Zip Code

_____

Relationship to Member

3. Protected Health Information to Disclose

Please describe the information covered by this authorization. I understand by leaving this section blank, I am authorizing the disclosure of my PHI, including my patient profile, and pharmaceutical records to my representatives. Description: _____

4. Expiration and Revocation

I understand that I have the right to end this authorization at any time. I understand that, if I do not wish the person named in Section 2 to remain my authorized representative, I must cancel this authorization **in writing** and fax notification to (405) 213-1518 or mail the notice to the address listed below.

MaxCare
PO Box 16430
Oklahoma City, OK 73113

Authorization to Use and Disclose Health Information

I understand that a cancellation of this authorization has no effect on disclosures or uses of PHI by MaxCare before receiving my cancellation notice.

I request that this authorization will expire on this date (MM/DD/YYYY):____/____/_____.

If I do not provide an expiration date, I am aware that this authorization is valid for sixty (60) months from the date of my signature as noted below.

5. **Authorization and signature of individual or individual's LEGAL representative**

I have read and understand the content of this Authorization to Use and Disclose PHI. This authorization describes my request of MaxCare. I understand, by signing this form, I am voluntarily giving my permission for MaxCare to use and/or disclose my PHI to the person named in Section 2. Any services otherwise provide to me by MaxCare will not be affected by my decision to provide this authorization.

_____

Member Signature Date

_____

Witness Signature Date

(A witness signature is only needed if the member is unable to sign or if the witness is an interpreter.)

If this authorization is signed on the member's behalf, by his/her legal representative, please attach documentation of legal representative designation and complete the following:

_____

Legal Representative's Name Date

_____

Mailing Street Address Apt#

_____

City State Zip

Relationship to Member: ☐ Family Member ☐ Friend ☐ Health Care Provider ☐ Other

If you listed "other", please describe _____

6. I understand that I have a right to request and receive a copy of MaxCare's Notice of Privacy Practices at http://my.maxcarerx.com/ ☐ Yes ☐ No

7. I understand that a photocopy of this authorization is as valid as the original ☐ Yes ☐ No

8. Fax the form to (405) 213-1518 or mail the completed form to:

MaxCare
PO Box 16430
Oklahoma City, OK 73113