Authorization for the Use and Disclosure of Protected Health Information
(45 CFR 164.508)

Section 1: Member Information

Member Name: _____ Date of Birth: _____ Member ID Number: _____

Address: _____ City: _____ State: _____Zip Code: _____

Section 2: Requesting Entity

Name of Entity or Individual _____ Telephone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Section 3: Information Requested

Description of the Protected Health Information to be released: _____

_____

Information to be released to: Name: _____

Address: _____ City: _____ State: _____Zip: _____

The information is being released for the following purpose: _____

_____

Section 4: Terms and Conditions

By signing below, I understand that:

- This authorization expires on the following date or event _____ or upon revocation by me in writing, whichever occurs first.
- I understand that I have the right to revoke or cancel this authorization at any time by providing notice in writing to the Managed Care Plan.
- If I revoke or cancel this authorization, it is not effective for the use or for the disclosure of my information that has already occurred.
- Any information used or disclosed as per this specific authorization may be re-disclosed by the person or entity receiving the information. In such a situation, it may no longer be protected from disclosure by federal or state law.
- I understand that this authorization is voluntary and that I may refuse to sign it. The provision of treatment, payment, enrollment in the health plan, or eligibility for benefits cannot be conditioned on the signing of this authorization. Unless the authorization is necessary for determining eligibility for the program or enrollment in the program.
- I have a right to inspect or copy the information that will be used or disclosed as per this authorization.

- I understand that in the event my records contain psychotherapy notes, a separate authorization may be required for the psychotherapy notes.
- I understand that this authorization permits the use and/or disclosure of information related to HIV testing or the treatment of AIDS or AIDS related conditions, drug or alcohol abuse, psychiatric conditions (excluding psychotherapy notes) unless specifically excluded above.

Section 5: Signature

By signing this document, I confirm that I have had full opportunity to read and consider the contents of this authorization, and confirm that the contents are consistent with my direction to the Managed Care Plan.

Member Name (Print) _____ Signature _____ Date _____

If signed by someone other than the Managed Care Plan member, describe your authority to act on behalf of the member.

Authorized Representatives name (Print) _____ Signature _____ Date _____

Return the completed form to:

☐ **Buckeye Health Plan**
ATTN: Member Service
3439 Easton Way, Ste 400
Columbus, Ohio 43219
FAX: 866.719.5435

☐ **CareSource**
Attn: Privacy Officer
P.O. Box 8738
Dayton, OH 45401-8738
HIPAAPrivacyOfficer@caresource.com

☐ **Molina Healthcare**
ATTN: Member and Provider Contact Center
3000 Corporate Exchange Drive
Columbus, Ohio 43231
MHOCompliance@MolinaHealthcare.com
FAX: 888.665.0860

☐ **Paramount**
ATTN: Member Services
1901 Indian Wood Circle
Maumee, Ohio 43537
Paramount.MemberServices@ProMedica.org
FAX: 419.887.2047

☐ **UnitedHealthcare Community Plan**
ATTN: Uniprise/C&S Project
3315 Central Avenue
Hot Springs, AR 71901
EC_CNS_CAID@uhc.com
Fax: 1-866-888-1129