Authorization to Use and Disclose Health Information

Notice to Member:

- Completing this form will allow Magnolia Health 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 give permission to use or share your health information. Your services and benefits with Magnolia Health will not change if you do not sign 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 the phone number on the back of your member ID card.
- Magnolia Health 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 the phone number on the back of your member ID card.
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- Fill in all the information on this form. When finished, mail the form and any supporting documentation to
- Magnolia Health Plan
- ATTN: Compliance Department
- 111 East Capitol Street, Suite 500
- Jackson, MS 39201

Aviso al (la) afiliado(a):

- Al llenar este formulario, usted autoriza a Magnolia *Health Plan* a (i) que use su información de salud para un fin en particular, y/o (ii) que la dé a conocer a la persona o entidad que usted identifique en este formulario.
- Usted no tiene que firmar este formulario ni dar permiso a usar o dar a conocer su información de salud. Sus servicios y beneficios de Magnolia *Health Plan* no cambiarán si usted no firma este formulario.
- Si desea cancelar este formulario de autorización, envíenos por escrito una solicitud para revocarlo a la dirección que aparece al final de esta página. Servicios para los afiliados puede proporcionarle un formulario de revocación si les llama al número telefónico que se encuentra en la parte trasera de su tarjeta de identificación de afiliación.
- Magnolia *Health Plan* no puede prometer que la persona o el grupo al que nos permita dar a conocer su información de salud no la dará a conocer a alguien más.
- Conserve una copia de todos los formularios llenos que nos envíe. Si las necesita, podemos enviarle copias.
- Si necesita ayuda, comuníquese con Servicios para los afiliados al número telefónico que aparece en la parte trasera de su tarjeta de identificación de afiliación.
- Llene toda la información en este formulario. Al terminar, envíe el formulario y todos los documentos de apoyo a

Magnolia Health Plan
ATTN: Compliance Department
111 East Capitol Street, Suite 500
Jackson, MS 39201

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

❶ MEMBER INFORMATION:

Member Name (print): _____

Member Date of Birth: _____ Member ID Number: _____

❷ I give Magnolia Health 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:

□ to allow Magnolia Health to help me with my benefits and services, **OR**

□ to permit Magnolia Health to use or share my health information for _____

❸ PERSON OR GROUP TO RECEIVE INFORMATION (add additional Persons or Groups on next age):

Name (person or group): _____

Address: _____

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

❹ I AUTHORIZE MAGNOLIA HEALTH TO USE OR SHARE THE FOLLOWING HEALTH INFORMATION (*NOTE: Select the first statement to release ALL health information or select the below 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 all boxes 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: _____

OR

Please specify record or type of records you would like to released:_____

❺ 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.

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❻ 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
Magnolia *Health Plan*, **ATTN: COMPLIANCE DEPARTMENT**
111 East Capitol Street, Suite 500, Jackson, MS, 39201

ADDITIONAL INDIVIDUAL PERSON(S) OR ENTITY(IES) 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:* ( ) -

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:* (_) ___ - _______

Statement of Non-Discrimination

Magnolia Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, religion, national origin, age, disability, sex, sexual orientation, gender, or gender identity. Magnolia Health does not exclude people or treat them differently because of race, color, religion, national origin, age, disability, sex, sexual orientation, gender, or gender identity.

Magnolia Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (18 point font or larger print, audio, accessible electronic formats, other formats)
- Provides free language services for those whose primary language is not English, such as:
  - Qualified Interpreters
  - Information written in other languages

If you need these services, contact Magnolia Health at 1-866-912-6285, Relay 711.

If you believe that Magnolia Health has failed to provide these services or discriminated in another way on the basis of race, color, religion, national origin, age, disability, sex, sexual orientation, gender, or gender identity, you can file a grievance with: Appeals Unit/ Appeals Coordinator, 111 E Capitol Street, Suite 500, Jackson, MS 39201, 1-866-912-6285, Relay 711, Fax 1-877-264-6519. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Magnolia Health is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1- 800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Magnolia Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-866-912-6285, Relay 711.
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Magnolia Health, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-866-912-6285, Relay 711.
Chinese:	**如果**您，或是您正在協助的對象，有關於 Magnolia Health **方面的問題**，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，**請撥電話** 1-866-912-6285, Relay 711。
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Magnolia Health, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-866-912-6285, Relay 711.
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Magnolia Health، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-866-912-6285,711 Relay .
Choctaw:	Chim ayalhpísah ihokih Chishno kiyokmat kanah ish apíla ka̲, Magnolia Health imma ná ponaklo hachim a̲shah ihokma̲. Apíla hicha ńan annówa ya̲ chim annopa anóli ako̲ hashísha hi̲nah kat. Ahíkachih kiyoh. Annopa tishóli imanópolih chinnakma, holhtina yappa̲ ipa̲yah 1-866-912-6285, Relay 711.
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Magnolia Health, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-866-912-6285, Relay 711**.**
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Magnolia Health hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-866-912-6285, Relay 711 an.
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Magnolia Health 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-866-912-6285, Relay 711 로 전화하십시오.
Gujarati:	જે તમને અથવા તમે જેમની મદદ કરી રહ્યા હોય તેમને, Magnolia Health વિશે કોઈ પ્રશ્ન હોય તો તમને, કોઈ ખર્ચ વિના તમારી ભાષામાં મદદ અને માહિતી પ્રાપ્ત કરવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા 1-866-912-6285, Relay 711 ઉપર કૉલ કરો.

Japanese:	Magnolia Health について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-866-912-6285, Relay 711 までお電話ください。
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Magnolia Health вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-866-912-6285, Relay 711.
Punjabi:	ਜੇ ਤੁਹਾਡੇ, ਜਾਂ ਤੁਹਾਡੀ ਮਦਦ ਲੈ ਰਹੇ ਕਿਸੇ ਵਿਅਕਤੀ ਦੇ ਮਨ ਵਿਚ Magnolia Health ਦੇ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹਨ. ਤਾਂ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਮੁਫਤ ਮਦਦ ਲੈਣ ਦਾ ਪੂਰਾ ਹੱਕ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ 1-866-912-6285, Relay 711 'ਤੇ ਕਾਲ ਕਰੋ।
Italian:	Se lei, o una persona che lei sta aiutando, avesse domande su Magnolia Health, ha diritto a usufruire gratuitamente di assistenza e informazioni nella sua lingua. Per parlare con un interprete, chiami l’1-866-912-6285, Relay 711.
Hindi:	आप या जिसकी आप मदद कर रहे हैं उनके, Magnolia Health के बारे में कोई सवाल हों, तो आपको बिना किसी खर्च के अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। किसी दुभाषिये से बात करने के लिए 1-866-912-6285, Relay 711 पर कॉल करें।