magnolia health

Member Authorization to Disclose Personal Health Information

(Please fill out the front and back of this form)

Use this form if you want Magnolia Health to give your personal health information to someone other than you. If you have any questions or need assistance filling out this form, please contact Magnolia Health toll free at **1-866-912-6285 (Relay 711)**.

Print Name (First and last name of Magnolia Health Member)	Medicaid Number	Date of Birth (mm/dd/yyyy)
_____	_____	____/____/____

Magnolia Health will only disclose the personal health information you want disclosed.

1. Check only **one** box below to tell Magnolia Health the specific personal health information you want disclosed.

   ❑ Limited information (go to question 2)

   ❑ Any information (go to question 3)

2. Complete only if you selected "limited information". Check **all** that apply.

   ❑ Information about your benefits

   ❑ Disclosure of your medical information

   ❑ Other specific information (please write below)

   _____

3. Check only **one** box below indicating how long Magnolia Health can use this authorization to disclose your personal health information.

   ❑ Disclose my personal health information until further notice.

   ❑ Disclose my personal health information for a specified period only beginning:

   (mm/dd/yyyy) _____ and ending (mm/dd/yyyy) _____

4. Fill in the name, address and phone number of the person(s) to whom you want Magnolia Health to disclose your personal health information. Please provide the specific name of the person(s) you list below.

Name: _____

Relationship to the Member: _____

Address: _____

Phone: (Area Code) _____

*****(Please fill out the back of this page)*****

5. Purpose for need of disclosure: The following is a specific description of the purpose of the requested use or disclosure. (The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.)

6. Expiration Date: This authorization is good until (indicate date or event)_____. By signing this authorization, I am confirming that it accurately reflects my wishes.

7. I authorize Magnolia Health to disclose my personal health information listed above to the person(s) I have named on this form. I understand that my personal health information may be re-disclosed by the person(s) and may no longer be protected by the law.

_____ _____

Signature Date (mm/dd/yyyy)

8. Send the completed, signed form to:
   Magnolia Health
   111 East Capitol Street, Suite 500
   Jackson, MS 39201
   Attention: Member Services Department

9. **Note:**

You have the right to take back ("revoke") your authorization at any time, in writing, except to the extent that Magnolia has already acted based on your permission. If you would like to revoke your authorization, send a written request to the address shown above. Your authorization or refusal to authorize disclosure of your personal health information will have no effect on your enrollment, eligibility for benefits or the health services you receive with Magnolia Health.

Magnolia must provide you with a copy of the signed authorization, and you have the right to inspect or copy the health information you have authorized to be used or disclosed by this authorization form. Magnolia may not use this authorization for marketing purposes. You will need to complete a separate authorization for any requests to use or disclose your psychotherapy notes with limited exception, which is for certain treatment, payment, or healthcare operations functions.

You have the right to understand the requirements of this authorization before you sign it. You also have the right to refuse to sign this authorization.

If you have any issues with this form or need help filling this form out, please call our toll free number at 1-866-912-6285 (Relay 711) and speak with one of our Member Services representatives.

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