Authorization for the Use and Disclosure of Protected Health Information

(Please, read and complete)
Member Information (Individual whose information will be disclosed)

Name: _____ Date of Birth: ____/____/_____
(Print Name) **Month / Day / Year**
Postal Address: _____
City: _____ State: PR Zip code: _____
Phone Number: ( ) _____-_____ Cell Phone Number: ( ) _____-_____
Member ID: _____

I hereby authorize MMM Multi Health to disclose my protected health information to the following organization or individual (or class of organizations or individuals):

_____
(Print name of authorized person)

Date of Birth: ____/____/_____ Phone Number: ( ) _____-_____
Month / Day / Year

Address: _____
City: _____ State: _____ Zip code: _____

Relationship with the beneficiary:
___ Son ___Spouse __Father __Mother ___Relative __Other: _____

Personal Identification Number: _____ Email Address: _____

_____
(Print name of authorized person)

Date of Birth: ____/____/_____ Phone Number: ( ) _____-_____
Month / Day / Year

Address: _____
City: _____ State: _____ Zip code: _____

Relationship with the beneficiary:
___ Son ___Spouse __Father __Mother ___Relative __Other: _____

Personal Identification Number: _____ Email Address: _____

1. I understand that the information that I am authorizing to disclose can be shared without being under the protection of federal privacy regulations.

2. The information that I authorize to be disclosed consists of any of the following:
   A. Claims
   B. Eligibility
   C. Information about organizational determinations for example, status (Pending, Approved and/or Denied)
   D. Others (please specify the information that you want to be disclosed:
   _____.

3. This information could be used for the following purposes (please, select all that apply):
   ___ Requested by the Member
   ___ Legal Procedure
   ___ To make changes of PCP, address or telephone, and/or request and id card duplicate.
   ___Other: _____.

4. I understand that the individual or organization authorized to receive and disclose information, will not receive monetary compensation for doing so.

5. I understand that this authorization is voluntary, and I can refuse to sign it. My refusal to sign this document will not affect my eligibility for benefits or enrollment, the payments or service coverage, or the ability to receive treatment.

6. I understand that I am entitled to receive a copy of this document.

7. I understand that I can revoke this authorization at any time by sending a written notification to MMM Multi Health Member Services to the following postal address PO Box 72010 San Juan PR 00936-7710.

8. I understand that I have the right to request and receive the MMM Multi Health Privacy Practices Notification.

***It is required to indicate the expiration date of this document. If you do not indicate a valid expiration date or if you do not fill the field provided below (in blank), this document will not have effect.**

***This authorization expires**: ____/____/____
(Month / Day / Year)

_____	_____
Member or Legal Representative Name (Print Name)	**Date**
_____	_____
Member or Legal Representative Signature	**Date**
_____	_____
Witness Signature	**Date**

(If the member signs with an "X", the signature of a witness is required)

***If this authorization is signed by the assigned legal representative, please provide evidence of legal representation as required by state law (e.g. Power of Attorney, Legal Guardianship)**

MMM Multi Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION**:** If you speak English or any other language, language assistance services, free of charge, are available to you. Call 1-844-336-3331 (TTY: 787-999-4411). MMM Multi Health 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障　或性別而歧視任何人。注意：如果您使用繁體中文，您可以免費獲得語言援助服務請致電 1-844-336-3331 (TTY: 787-999-4411)