AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Member Name:			**Member ID #:**
Member Address:			**Date of Birth:**
City:	**State:**	**Zip:**	**Phone #:**

I authorize the use or disclosure of my protected health information (PHI) as stated below.

1. Name and address of Molina Healthcare (Molina) entity authorized to use or disclose the PHI:

2. Name and address of person or organization authorized to receive or use the PHI:

3. Description of the PHI that may be used and/or disclosed*:
   All of my health information including, but not limited to, my medical records, health care claims, authorizations, medications and provider information.

   *I know that this may include PHI related to:

   - Sexually transmitted diseases;
   - HIV/AIDS;
   - Other communicable diseases;
   - Behavioral or mental health diseases; and
   - Referral and/or treatment for substance use disorder (as permitted under 42 CFR Part 2)

4. The PHI will be used and/or disclosed for the following purpose(s):
   To help me with my health care, payment for health care or coordination of my health care.

5. I know that:

   a. This authorization is voluntary.
   b. I do not have to sign this form. I can refuse to.

c. My refusal to sign will not affect any of the following:
   - My eligibility for benefits or enrollment;
   - Payment for services; or
   - My ability to be treated

d. I have a right to get a copy of this form. I must ask for a copy.

e. I may revoke this authorization at any time. To do so I have to let Molina know in writing. Such revocation will not apply to actions that Molina has taken in reliance on this authorization.

f. The PHI I authorize a person or entity to get may no longer be protected by federal law and regulations.

6. This authorization will expire on this date or event* : _____
**If not stated above, this authorization will expire 12 months from the date below.*

Signature of Member or Member's Personal Representative	Date

Personal Representative's Name, if applicable (please print): _____

Relationship to Member: □Parent □Legal Guardian* □Holder of Power of Attorney *

□Other Please Describe: _____

*** Please attach legal documentation if you are the legal guardian or Holder of Power of Attorney for Healthcare Decisions**

A copy of this signed form will be given to the Member, if Molina sought it.

Contact Information

If you have any questions, please contact the following:

Molina Healthcare of South Carolina, LLC
Attn: Compliance Department
4105 Faber Place Drive, Suite 120
North Charleston, SC 290405
Molina Healthcare of South Carolina Member Services (855) 882-3901