Meridian Health Plan

Authorization for Release of Protected Health Information

Member Name: _____ Medicaid ID #: _____

Address: _____ Date of Birth: _____
(MM/DD/YYYY)

City/State/Zip: _____ Phone #: _____-_____-_____

I request and authorize Meridian Health Plan (MHP) to release personal and medical information which MHP maintains and which may include records regarding general medical care, alcohol and drug abuse treatment, psychological or psychiatric treatment, social services counseling, Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC), communicable diseases or infections, venereal diseases, tuberculosis, hepatitis and all other medical records. I understand that MHP will not condition (make available or deny) treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

1. **Reason for the Disclosure: (Choose One)**
   - ☐ To help coordinate my health care
   - ☐ For a lawsuit, legal action, court case, settlement, etc.
   - ☐ Other: _____
2. **Disclosure to be made to the following individual:**
   Name (First, Last): _____ Phone #: _____-_____-_____
   Address: _____
   City: _____ State: _____ Zip: _____
3. **What type of information should be disclosed? (Choose One)**
   - ☐ My entire medical record
   - ☐ Specific protected health information: _____
4. **When does this authorization expire? (Choose One)**
   - ☐ On the following date (MM/DD/YYYY): _____
   - ☐ One year from the date it is signed.
   - ☐ When I am no longer a member of MHP.

I understand that I may refuse to sign this authorization and that I may revoke it at any time, but I must do so in writing to Chief Privacy Officer; Meridian Health Plan; 222 North LaSalle St, Suite 930; Chicago, IL 60601. I understand that any revocation will not be effective with respect to any information that has already been released when my revocation is received by Meridian Health Plan. I understand that I have the right to receive a copy of this authorization after it is signed. I understand that the persons to whom information is disclosed under this authorization may possibly re-disclose the information to others without my knowledge or consent and therefore the privacy of my medical records may no longer be protected by law. I sign this authorization **(choose one)**:

☐ On behalf of Myself
☐ On behalf of my Minor Child
☐ In my role as Legal Guardian of the Member
(Guardianship Papers must be attached or already on file with MHP)

Signature: _____ Date Signed: _____
(MM/DD/YYYY)