Authorization to Use or Disclose Protected Health Information (PHI)

Medi-Cal Rx

Consent to Release Protected Health Information

On behalf of the Department of Health Care Services (DHCS), this form gives Magellan Medicaid Administration, Inc. (MMA), as the contracted entity that provides pharmacy administrative services relative to Medi-Cal Rx, permission to use or disclose your Protected Health Information (PHI) to another person or entity about your pharmacy services, and MMA will only provide that information. PHI is information about your health. Federal and state laws protect the privacy of your PHI. By signing this form, you give us your approval. We will only give out the PHI that you say we can share and to the people or entities that you list.

It is important that all fields with an asterisk (*) are filled in with the correct information. If not, this form will not be accepted. Do you have questions? We can help. Call the **Medi-Cal Rx Customer Service Center** at (800) 977-2273.

***Check One:**

☐ I am the beneficiary **– OR –**

☐ I have the legal right to act for this person. Check one below; if "Other," fill in the blank:

I am his/her: ☐ Guardian ☐ Attorney ☐ Power of Attorney ☐ Other: _____

(*Provide supporting documentation of authorization to sign on behalf of the beneficiary.)

SECTION 1 – WHO IS THE BENEFICIARY?

*Last Name: _____ *First Name: _____ MI: ____

*Date of Birth: _____ *Medi-Cal ID (BIC) #: _____ Phone #: _____

*Street Address (if applicable/allowed by law): _____

*City: _____ *State: _____ *Zip: _____

SECTION 2 – WHO CAN GIVE OUT THE PHI?

By signing this form, you give MMA (on behalf of DHCS), which manages your pharmacy benefits, the approval to share your PHI.

SECTION 3 – TO WHOM CAN THE PHI BE GIVEN?

*Name (a person or an organization): _____

Phone # (if known): _____ Street Address (if known): _____

City: _____ State: _____ Zip: _____

SECTION 4 – WHAT PHI CAN WE SHARE?

*Tell us exactly the information from your health records that we can share with the person or organization you named above: _____

☐ All health information in your profile **– OR –** ☐ Other: _____

We will only share the PHI that you approve. Please be specific. Examples are medication name, dates of services, pharmacy name, names of medical providers, medical condition, etc.

SECTION 5 – WHY DO YOU WANT US TO SHARE YOUR PHI?

*Tell us why you want us to share your PHI. *You can just say "at the beneficiary's request."*

☐ At the beneficiary's request **– OR –** Reason you want to share your PHI:

_____

SECTION 6 – WHEN DOES THIS APPROVAL END?

Your approval will end when you tell us it does.

***Check One:**

☐ My approval ends on _____ / _____ / _____ (It cannot be more than one year from the date of your approval) **– OR –**

☐ My approval ends when this happens: _____

It can be something like "You can share my pharmaceutical records this one time."

If you do not tell us when your approval ends, your approval will end one year from the date you sign this form. After one year, we will need a new form completed.

SECTION 7 – YOUR RIGHTS AND IMPORTANT FACTS

- You do not have to provide your approval to share your information. Giving your approval is up to you. You will still get benefits and treatment.
- **You may revoke your approval at any time by writing to the address in Section 10 below.**
- If you revoke your approval, it will not take back the PHI that we have already shared. But we will not share any more of your PHI.
- If we share your PHI with the people or agencies that you named, they may share it with others. Not everyone has to follow privacy rules.
- You have a right to get a copy of this signed form. If you need another copy, call **Medi-Cal Rx Customer Service Center** at (800) 977-2273.
- If you do not understand or if you have questions, we can help. Call **Medi-Cal Rx Customer Service Center** at (800) 977-2273.

***A SIGNATURE AND DATE ARE REQUIRED IN EITHER SECTION 8 OR 9 BELOW.**

SECTION 8 – BENEFICIARY SIGNATURE

Required if the beneficiary is completing this form. I give my approval to share the information listed on this form.

Signature: _____ *Date:* _____

– OR –

SECTION 9 – SIGNATURE OF PERSON LEGALLY AUTHORIZED TO SIGN FOR BENEFICIARY (i.e., Power of Attorney, etc.)

Required if a personal representative is completing this form. Personal representative means that you have legal proof that you can act for the beneficiary. A representative can sign for a person who cannot legally sign on his/her own. I give my approval to share the information listed on this form.

Name: _____ Phone #: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Signature: _____ *Date:* _____

SECTION 10 – WHERE DO I SEND THIS FORM?

Please return the completed and signed authorization form to **Medi-Cal Rx Customer Service Center**. If you have questions about how to complete this form, please contact us.

Mailing Address	Phone/Fax
Medi-Cal Rx Customer Service Center Attn: Authorization Form PO Box 730 Rancho Cordova, CA 95741-0730	Phone: (800) 977-2273 Fax: (800) 869-4325

Notice to Recipient of Information

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.