Authorization to Use or Disclose Protected Health Information (PHI)

MagellanRx MANAGEMENT℠

Consent to Release Protected Health Information

This form gives Magellan Rx permission to use or disclose protected health information to another person or entity. Protected Health Information (PHI) means information about your health. Federal and State laws protect the privacy of your PHI. The laws say we cannot give anyone other than your medical and pharmacy providers or Magellan Rx Management (Magellan Rx) your PHI unless you say it is okay. By signing this form, you give us your approval. We will only give out the PHI that you say we can share. We will only give it to the people or agencies that you list.

It is important that all fields with an asterisk (*) are filled in with correct information. If not, this form will not be accepted. Do you have questions? We can help. **Call Magellan Rx at 1-800-424-3312.**

*Check one:

☐ I am the member.

– OR –

☐ I have the legal right to act for this person. Check one of the 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 member)

SECTION 1 – WHO IS THE MEMBER?

*Last Name: ____________________ *First Name: ____________________ Middle Initial: ______

*Date of Birth: ____________ *ID Number/MBI: ________________ Phone Number: ______________

*Street Address (IF APPLICABLE AND ALLOWED BY LAW): ________________________________

*City: ______________________________ *State: __________ *ZIP Code: ______________

SECTION 2 – WHO CAN GIVE OUT THE PHI?

By signing this form, you give Magellan Rx the approval to share your PHI. Magellan Rx manages your pharmacy benefits.

SECTION 3 – TO WHOM CAN THE PHI BE GIVEN?

*Name (A PERSON OR AN ORGANIZATION): ________________________________

Phone Number (IF KNOWN): ______________ Street Address (IF KNOWN): ______________________

City: ________________________ State: ________________ ZIP Code: ______________

SECTION 4 – WHAT PHI CAN WE SHARE?

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

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. ***A request to share "Everything" will not be approved.***

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 member's request."*

☐ At the member's request – OR –

Reason you want us 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 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, then your approval will end one year from when 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 Magellan Rx by referring to the number on your ID card or by calling 1-800-424-3312.
- If you do not understand or if you have questions, we can help. Call Magellan Rx by referring to the number on your ID card or by calling 1-800-424-3312.

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

SECTION 8 – MEMBER SIGNATURE

Required if the member 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 MEMBER (i.e. Power of Attorney, etc.)

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

Printed Name: ______________________________ Phone Number: ____________________

Street Address: ____________________ City: ____________________ State: ________ ZIP Code: ____________

Signature: ______________________________ *Date:* ____________________

SECTION 10 - WHERE DO I SEND THIS FORM?

Please return completed and signed authorization form to Magellan Rx Management. If you have questions about how to complete this form, please contact us at any of the below.

Mailing Address:
Magellan Rx Management
Attn: Member Services
4801 E Washington Street
Phoenix, AZ 85034

Phone/Fax
Phone: 800-424-3312
Fax: 800-424-3260

E-mail Address:
ERxResponseTeam@magellanhealth.com

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.

* The Magellan Rx Management business division includes the following entities and their subsidiaries: Magellan Rx Medicare, Magellan Rx Pharmacy, LLC, Magellan Method, LLC, Magellan Rx Management, Inc., Magellan Pharmacy Solutions, Inc., Magellan Medicaid Administration, Inc., Magellan Administrative Services, Inc., 4-D Pharmacy, and Veridicus Holding, LLC.

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