maryland physicians care
Medicaid with a Heart

Privacy Authorization Form

Date: _____

Member Name: _____ Member Date of Birth: _____ Member ID #: _____

Address: _____ Phone: (___) _____
Street City, State Zip

Are you the member? Yes No **If "NO", tell Maryland Physicians Care, Incorporated ("the Plan") who you are by checking one of the boxes below. Please give the Plan copies of any papers that show you have the right to make this request.**

- ☐ I am the member's Dad/Mom or guardian.
- ☐ I make health care decisions for the member.
- ☐ The member has died, and I take care of his or her assets.
- ☐ Other (explain) _____

Name of Requestor (if not member): _____ Date of Request: _____

Requestor Address (if not member): _____
Street City, State Zip Telephone Number

I want the Plan to use or give out records of the member named above because:

- ☐ I (the member or person acting for the member) want the Plan to give out the information described below.
- ☐ To help the Plan coordinate the member's health care
- ☐ For workers' compensation claims
- ☐ For insurance coverage or payment for care
- ☐ Other (tell us): _____

You may / may not (check box that applies) give out any records about:

- ☐ AIDS/HIV testing or other information
- ☐ Other communicable disease (e.g. venereal disease)
- ☐ Mental health information (including behavioral health and psychiatric care)
- ☐ Alcohol and/or drug abuse treatment
- ☐ Genetic testing information

I authorize the Plan to use or give out records of the member named above to

Enter name of person/entity: _____

Enter address, phone and fax number if known: _____

Tell the Plan what you want us to give out. You need to provide dates of service, provider names, etc.

_____

I (the member or person acting for the member) agree to the following:

- I may authorize the Plan to use or give out member records. When I give an approval, the Plan will give out member records to a person or company.
- I know that member records can't always be kept safe under privacy laws. I know a person or company that receives member records can give them out again.
- I may take back this authorization by submitting to the Plan a request in writing.
- I may not be allowed to take back an authorization in some cases. I can learn more about this in the Plan's Notice of Privacy Practices.
- This authorization will end in twelve (12) months from the date of signature.
- If I want this authorization to end before this date, I will tell the Plan. I will tell the Plan when I want it to end and the reason. Use the space below to explain:

_____

- I am entitled to receive a copy of this form.
- I have read and understand this form.

The information authorized for release may include records, which may indicate the presence of a communicable or venereal disease, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

_____ _____

If member - Signature of Member Date

_____

If member -Print Member Name

_____ _____

If not member - Signature of Legal Representative Date

_____

Print Name of Legal Representative

Please send this Privacy Authorization Form to:

Maryland Physicians Care
Attn: Privacy Officer
1201 Winterson Rd, 4th
Floor. Linthicum, MD 21090

Reviewed: March 2014