RETURN COMPLETED FORM TO: MHN Legal and Regulatory Affairs
2370 Kerner Blvd
San Rafael, CA 94901

AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION BEHAVIORAL HEALTH / SUBSTANCE ABUSE FOR MHN MEMBERS

EXPLANATION

This authorization for use or disclosure of medical information complies with applicable State and Federal laws and regulations, including federal HIPAA privacy regulations, 45 C.F.R. Section 164.508: 42 U.S.C. Section 290 dd-2 and 42 C.F.R. Section 2.1 et seq. as applicable.

AUTHORIZATION

I hereby authorize MHN to furnish to _____ information pertaining to medical history,
(Name of person receiving information)

behavioral health condition, alcohol and/or drug abuse services, services rendered, or treatment of _____
(Name of member/patient)

This authorization is limited to the following medical records and type of information obtained in the course of the diagnosis and treatment for Behavioral Health and/or in the course of the diagnosis and treatment for alcohol and/or drug abuse: _____

_____

USES

MHN may disclose this type of information only for the following purposes:

_____

_____

DURATION

This authorization shall become effective immediately and shall remain in effect until [date] _____, 200____.

RESTRICTIONS

I understand that MHN may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

NOTICE

Information used or disclosed pursuant to an authorization may be subject to redisclosure by the recipient and no longer protected by the federal health information privacy regulations.

MY RIGHTS

I may revoke this authorization in writing at any time as set forth in MHN's Notice of Privacy Practices.

Neither payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. This restriction does not apply if MHN is seeking to obtain information in connection with my eligibility or enrollment with MHN when I am not already a member or to obtain information required for payment of a specific claim for benefits.

I have a right to receive a copy of this authorization.

SIGNATURE

Date: _____ Signature: _____

Member Name: _____ Member Number: _____

If signed by other than patient, indicate relationship: _____
[patient representative/spouse*/financially responsible party*]

*A spouse or financially responsible party may only authorize release of medical information for use in processing an application for the patient, as a spouse or dependent, for a health insurance plan or policy, a nonprofit hospital plan, a health care service plan or an employee benefit plan.

Current Address and Telephone Number: _____

IDENTIFICATION REQUIRED

Please provide a **legible** photocopy of your driver's license or state identification card, for signature verification.

MHN will not release your records without valid identification.