Authorization for the Use and Disclosure of Protected Health Information.
(Please, read and fill out. All fields are required)
Member Information (Individual whose information will be disclosed)

Name: (Print Name)

Date of Birth: - - (Month Day Year)

Phone number: - -

Cell phone number: - -

☐ Text (MMS) ☐ Data (SMS)

Member ID Number:

Email address: _____

Address:

City:

State:

Zip Code: -

I hereby authorize MMM of Florida, Inc. (MMM of Florida) to disclose my protected health information to the following organization or individual:

Name: (Print Name)

Date of Birth: - - (Month Day Year)

Phone number: - -

Cell phone number: - -

☐ Text (MMS) ☐ Data (SMS)

Relationship with the beneficiary:

☐ Son ☐ Daughter ☐ Father ☐ Mother ☐ Spouse ☐ Relative ☐ Other: _____

Personal Identification Number (PIN): _____

☐ License ☐ Passport ☐ Real ID

Email Address: _____

Address:

City:

State:

Zip Code: -

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_____

1. I understand that the information that I am authorizing to disclose can be shared without being under the protection of federal privacy regulations.

2. The information that I authorize to be disclosed consists of any of the following:
   Demographic information, claims and payment, encounter data, eligibility and enrollment, benefits and coverage, clinic information related to treatment, diagnosis [illness name or condition], procedures received, interventions, medical care plans [not including psychotherapy notes], laboratories, medical records, information to identify providers of care [physicians, hospitals, laboratories, etc], information about organizational determinations, MTM [Medication Therapy Management Program] or
   Other: _____

3. This information could be used for the following purposes (please, select all that apply):
   - ☐ Requested by Member
   - ☐ Legal Procedure
   - ☐ To make changes of PCP, address or telephone, and/or request an id card duplicate.
   - ☐ Other: _____

4. I understand that the individual or organization authorized to receive and disclose information, will not receive monetary compensation for doing so.

5. I understand that this authorization is voluntary and I can refuse to sign it. My refusal to sign this document will not affect my eligibility for benefits or enrollment, the payments or service coverage, or the ability to receive treatment.

6. I understand that I can receive a copy of this document.

7. I understand that I can revoke this authorization at any given time by sending a written notification to MMM of Florida Member Services PO BOX 260430, Miami, FL 33126.

8. I understand that I have the right to request and receive the MMM of Florida Privacy Practices Notification.

***It is required to indicate the expiration date of this document. If you do not indicate a valid expiration date or if you do not fill the field provided below (in blank), this document will not have effect.**

***This authorization expires:** ☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

Member or Legal Representative Name: (Print Name) **Date:**

_____ _____

Member or Legal Representative Signature: **Date:**

_____ _____

Witness Signature: **Date:**
(If the member signs with an "X", the signature of a witness is required)

_____ _____

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If this authorization is signed by the assigned legal representative, please provide any representative documentation as required by state law (e.g. Power of Attorney, Legal Guardianship).

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