HIPAA Authorization Form

A HIPAA Authorization lets you give Meridian Medicaid Plan (Meridian) permission to share your Protected Health Information (PHI) with a person or entity you choose. Your info may include general medical care, alcohol and drug abuse treatment, psychological or psychiatric treatment, social services counseling, Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC), communicable diseases or infections, venereal diseases, tuberculosis, hepatitis and all other medical records.

SECTION 1: YOUR INFO			
Name (First and Last):		Date of Birth (MM/DD/YYYY):	
Member ID#:		Phone Number:	
Address:	City:	State:	Zip:

SECTION 2: REASON	
☐ To help with my healthcare	☐ For a lawsuit, legal action, court case, settlement, etc.

☐ Other

SECTION 3: PERSON WE MAY DISCLOSE TO			
Name (First and Last):		Phone Number:	
Address:	City:	State:	Zip:

SECTION 4: WHAT TYPE OF INFO MAY BE SHARED? (CHOOSE ONE)	
☐ My entire medical record	

☐ Only limited information (such as specific treatments, dates of services or billing details):

☐ Other:

SECTION 5: WHEN WILL THIS EXPIRE?	
☐ One year from the date signed	☐ When I am no longer a member of this health plan for more than six months

☐ Other:

SECTION 6: SIGN AND DATE (CHOOSE ONE)

I understand that I am not required to sign this form. This info is being released upon my request. Meridian will not make available or deny my treatment, payment or my enrollment or eligibility for benefits based on if I sign this form. Info disclosed because of this form may be disclosed by the recipient and may not be protected by federal privacy rules. I understand I have the right to take away this authorization at any time by sending written revocation to Meridian. Meridian can provide me with a form to revoke if I need one. I understand my revocation will not apply until Meridian has it and only for info that is not already released under this form.

Who is signing? ☐ Member listed above ☐ Parent of minor member listed above
☐ Someone other than member*

Signature:_____ Date:_____

Name (printed): _____

*Description of authority to act on behalf of the member (e.g., durable power of attorney, court order, parent of minor child, etc.): _____

You must attach the legal records shown above that name you as the representative of this member. There will be delays in this request if you do not give us this info.

SECTION 7: RETURN THE FORM

Send us a copy of this form by choosing one of the following:

1. Fax this form to 844-751-1870
2. Email this form to privacy.il@mhplan.com
3. Send this form by mail to the address below:

Meridian Medicaid Plan
ATTN: Member Services
1333 Burr Ridge Parkway, Suite 100
Burr Ridge, IL 60527