



Instructions for Completing the MPIHP Authorization for Release of Health Information

Submitting this Authorization Form is Optional. You do not need to submit it to the Plan Office unless you want someone else to have access to your protected health information (“PHI”) such as your spouse, a family member, a friend, your Union, etc. This is your choice. Also, you do not need to submit an authorization form in order for the MPI Health Plan (“Plan”) to pay your claims. Submitting this authorization form will not affect your coverage.

Only One Person Per Form: Only one person may give their authorization per form.

You **Must** Fill in the **Following Information** on the form, otherwise the Plan cannot accept your Authorization request.

- **Name** - must be printed in the “Print Name” blank. One of the boxes specifying “Participant”, “Spouse”, or “Dependent” *must* also be selected.
 - **Date of Birth** - must be filled in the “Date of Birth” blank.
 - **Participant’s ID or SSN** must be entered.
 - **Your Entire Address** currently on record must be filled in the “Address” blank.
 - **Phone Numbers** - the Plan Office must have a way to reach you during normal business hours. Please include at least one phone number for this purpose.
1. **Description of the Health Information to be Used or Disclosed:** This is where you must specify the type of PHI the MPI Health Plan will provide upon request. You can specify more than one type.
 2. **Persons/Organizations Authorized to Receive and/or Disclose My Health Information**
 - You *must* specify the person(s) or class of persons designated to receive your information upon their request.
 - Next, indicate the purpose for this authorization.
 3. **Expiration of This Authorization:** This is where you tell us when your authorization will expire. You *must* complete one option. If you list the third option “Upon the occurrence of the following event(s)...”, you *must* enter the event, or have entered a specific reason under Item #2.
Note: If your authorization expires, no information can be provided without submitting a new authorization.
 4. **Your Rights with Respect to This Authorization** explains your rights. Please read.
 5. **Confirmation/Signature.** You *must* complete this section or the form will not be accepted.
 6. **Complete this Section Only if a Personal Representative is Used.** Only fill in this section if you are being represented by someone.

IF YOU HAVE QUESTIONS ABOUT THIS FORM, CALL THE PLAN OFFICE AT

818 OR 310.769.0007, EXT. 316



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

4. Your Rights with Respect to This Authorization

4.1. Right to Revoke

I understand that I have the right to revoke this authorization at any time by submitting my revocation in writing to the MPI Health Plan. I also understand that my revocation of this authorization must be in writing. To obtain a copy of an "Authorization Revocation Form," I may contact the MPI Health Plan: 818 or 310.769.0007, Ext. 251. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the MPI Health Plan, person(s) and/or organization(s) identified in Section 2 of this form have already made in reliance upon this Authorization.

4.2. Right to Receive a Copy of This Authorization

I understand that if I agree to sign this Authorization, which I am not required to do, I must be provided with a signed copy of it if so requested.

5. Confirmation/Signature

By signing this authorization form, I authorize the MPI Health Plan to disclose my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996) in the manner described on page 1. *I understand that I am under no obligation to sign this form and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.*

I, _____ have had an opportunity to review
Print Name *Participant's ID or SSN*

and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

Signature of Participant, Spouse or Dependent (age 18 or older) *Date*

6. Complete this Section Only if a Personal Representative is Used

If this Authorization is to be signed by a Personal Representative, that Personal Representative must complete this section before this form will be considered valid.

Print Name of Personal Representative *Relationship to Participant*

Address: _____
Street, City, State, ZIP Code

Phone Numbers: _____
Daytime *Home* *E-Mail Address (optional)*

Signature of Personal Representative *Date*

**RETURN FULLY COMPLETED FORM PLUS A COPY OF THE POWER OF ATTORNEY, IF APPLICABLE,
TO THE MPI HEALTH PLAN OFFICE:**

**CLAIMS REVIEW UNIT—MPI HEALTH PLAN
P.O. Box 1999
STUDIO CITY, CA 91614-0999**