

MEDICAL RECORDS RELEASE FORM

Member Name:	Date of Birth:
Address:	
Social Security Number:	Telephone Number:
<p>I hereby authorize _____ to release the health information that is contained in my patient records to my health plan—Magellan Complete Care. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/Aids test results or diagnosis. Please mail all medical records within thirty (30) days to:</p> <p>Magellan Complete Care Attn: Medical Records Department PO Box 524083 Miami, FL 33152 1-800-327-8613 1-800-424-1694 (TTY)</p> <p>If the requested portion of the record contains information pertaining to mental health or drug or alcohol treatment or contains HIV related information, you must specifically authorize the release of such information by initialing one or both of the following:</p> <p><input type="checkbox"/> I understand that if my record contains information concerning mental health and/or drug and alcohol treatment, such information will be released pursuant to this authorization.</p> <p><input type="checkbox"/> I understand that if my record contains confidential HIV related information, such information will be released pursuant to this authorization form. Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.</p> <p>I know I do not have to allow release of HIV related information and that I can change my mind at any time before it is released. If I experience discrimination because of release of HIV confidential information, I can call the Florida Agency for Health Care Administration at (850) 488-3849 and/or the United States Department of Health and Human Services at 1-800-368-1019 or at www.hhs.gov/ocr.</p> <p>This authorization will automatically expire within six months from the date of signature.</p> <p style="text-align: right;"><i>continued on the reverse</i></p>	



I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the medical records. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that Magellan Complete Care may release medical information to the federal and state governments or their duly appointed agents as required.

I also understand that I have the right to refuse to sign this authorization. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form. You also have a right to receive a copy of this form after you have signed it.

I also understand that in an effort to prevent unauthorized re-disclosure provider may attach a notice when sending out records that states, "re-disclosure is prohibited". However, the potential for an unauthorized re-disclosure may not be protected by federal confidentiality rules.

I also understand that in order to process this request to reproduce medical record information on a timely basis, in which I am requesting information from, may utilize a photocopy service and my signature authorizes the release of information to such photocopy service for the purpose of satisfying this request.

Signature of Patient/Representative/Legal Guardian

Date

Print Name of Patient/Representative/Legal Guardian

Contact Telephone Number:	Relationship if not Patient*:
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*If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany the request, e.g. appointed guardian, durable power of attorney for health care).
EXCEPTION—parent signing for a patient under the age of eighteen.