Instructions for completing the Member Authorization Form

If you have any questions, please feel free to call us at the Member Services number on your member identification card. Please read the following to complete page one of the form.

Part A: Member information

This section applies to the member who is asking for the release of his or her information to another person or company.

1. Write your last name, first name, and middle initial.
2. Write your date of birth in this format: **mmddyyyy.** (If you were born on October 5, 1960, you would write 10051960.)
3. Write your full street address, city, state, and ZIP code.
4. Write your daytime phone number (including area code.)
5. Write your cell/mobile number (including area code.)
6. Identification number
   You will find this number on your member identification card.
7. Group number
   You will find this number on your member identification card. If your identification card does not have a group number leave this blank.

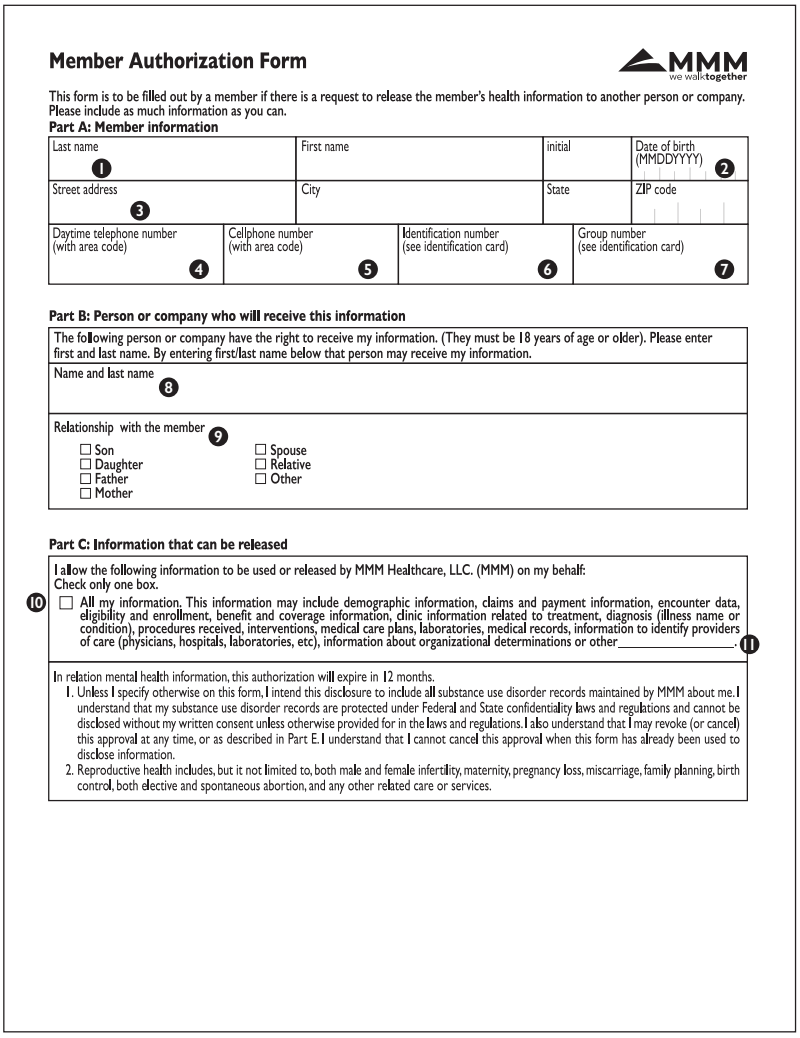
Part B: Person or company who will receive this information

8. Write the full name of the person or company that you want us to give your information to. Please don't use a general term like "my daughter" or "my son" as it will not be accepted.
9. Choose the relationship with you of the person that you are authorizing in this document.

Part C: Information that can be released

This section tell us what information you would like to release.

10. For "all of your information," check the first box.
11. Write an additional information that you authorize us to disclose under this authorization (if applicable).



Member Authorization Form

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This form is to be filled out by a member if there is a request to release the member's health information to another person or company. Please include as much information as you can.

Part A: Member information

Last name 1	First name	initial	Date of birth (MMDDYYYY) 2
Street address 3	City	State	ZIP code

Daytime telephone number (with area code) 4	Cellphone number (with area code) 5	Identification number (see identification card) 6	Group number (see identification card) 7

Part B: Person or company who will receive this information

The following person or company have the right to receive my information. (They must be 18 years of age or older). Please enter first and last name. By entering first/last name below that person may receive my information.

Name and last name 8

Relationship with the member 9

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

Part C: Information that can be released

I allow the following information to be used or released by MMM Healthcare, LLC. (MMM) on my behalf:
Check only one box.

10 ☐ All my information. This information may include demographic information, claims and payment information, encounter data, eligibility and enrollment, benefit and coverage information, clinic information related to treatment, diagnosis (illness name or condition), procedures received, interventions, medical care plans, laboratories, medical records, information to identify providers of care (physicians, hospitals, laboratories, etc), information about organizational determinations or other_____. 11

In relation mental health information, this authorization will expire in 12 months.

1. Unless I specify otherwise on this form, I intend this disclosure to include all substance use disorder records maintained by MMM about me. I understand that my substance use disorder records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time, or as described in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.
2. Reproductive health includes, but it not limited to, both male and female infertility, maternity, pregnancy loss, miscarriage, family planning, birth control, both elective and spontaneous abortion, and any other related care or services.

Please read the following for help completing page two of the form.

Part D: Purpose of this approval

This section tells us the reason you've asked for the release of your information.

1. Check the first box to let us know that we can give out this information as shown on this form.
2. Check the second box for a specific reason. An example might be to settle a life insurance claim.

Part E: Date your approval expires

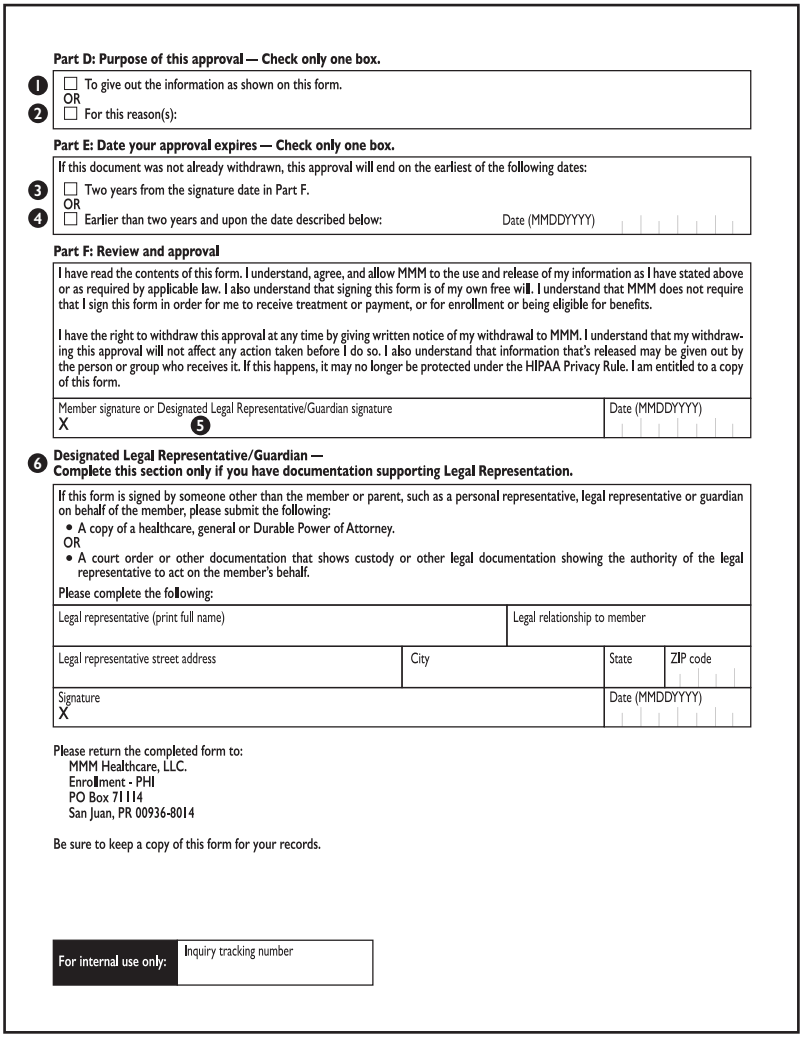
You have two choices of when you would like this approval to end.

3. Check the first box for the standard 2 years that it will end.
4. Check the second box for an earlier date (other than 2 years), and give the date you wish this approval to end.

Your authorization/approval can't be granted for more than 2 years.

Part F: Review and approval

5. Sign your name and put the date on the form. Your name and signature must match the information in Part A.
6. If you are signing this form on behalf of another person, or if you have Power of Attorney for healthcare, or are a legal guardian/conservator you must do the following:
   - You must complete the Designated Legal Representative/Guardian section.
   - You must also provide us with a copy of the legal document showing that you are approved and include it with this form.



Part D: Purpose of this approval — Check only one box.

1 ☐ To give out the information as shown on this form.
OR
2 ☐ For this reason(s):

Part E: Date your approval expires — Check only one box.

If this document was not already withdrawn, this approval will end on the earliest of the following dates:

3 ☐ Two years from the signature date in Part F.
OR
4 ☐ Earlier than two years and upon the date described below: Date (MMDDYYYY)

Part F: Review and approval

I have read the contents of this form. I understand, agree, and allow MMM to the use and release of my information as I have stated above or as required by applicable law. I also understand that signing this form is of my own free will. I understand that MMM does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to MMM. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Member signature or Designated Legal Representative/Guardian signature	Date (MMDDYYYY)
X 5	

6 **Designated Legal Representative/Guardian — Complete this section only if you have documentation supporting Legal Representation.**

If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following:

- A copy of a healthcare, general or Durable Power of Attorney.

OR

- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

Please complete the following:

Legal representative (print full name)	Legal relationship to member		
Legal representative street address	City	State	ZIP code
Signature X			Date (MMDDYYYY)

Please return the completed form to:
MMM Healthcare, LLC.
Enrollment - PHI
PO Box 71114
San Juan, PR 00936-8014

Be sure to keep a copy of this form for your records.

For internal use only:	Inquiry tracking number

Examples of legal documents:

- Healthcare, General or Durable Power of Attorney. This document gives someone you trust the legal power to act on your behalf and make health care decisions for you.
- Legal Guardianship. This is when the court appoints someone to care for another person.
- Conservatorship. This happens when a judge appoints a responsible person to make decisions for someone who can't make responsible decisions for him/herself.
- Executor of estate. This type of document would be used when the person who is being represented has died.

Member Authorization Form

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This form is to be filled out by a member if there is a request to release the member's health information to another person or company. Please include as much information as you can.

Part A: Member information

Last name	First name	initial	Date of birth (MMDDYYYY)
Street address	City	State	ZIP code

Daytime telephone number (with area code)	Cellphone number (with area code)	Identification number (see identification card)	Group number (see identification card)

Part B: Person or company who will receive this information

The following person or company have the right to receive my information. (They must be 18 years of age or older). Please enter first and last name. By entering first/last name below that person may receive my information.

Name and last name

Relationship with the member

- ☐ Son
- ☐ Daughter
- ☐ Father
- ☐ Mother
- ☐ Spouse
- ☐ Relative
- ☐ Other

Part C: Information that can be released

I allow the following information to be used or released by MMM Healthcare, LLC. (MMM) on my behalf:
Check only one box.

☐ All my information. This information may include demographic information, claims and payment information, encounter data, eligibility and enrollment, benefit and coverage information, clinic information related to treatment, diagnosis (illness name or condition), procedures received, interventions, medical care plans, laboratories, medical records, information to identify providers of care (physicians, hospitals, laboratories, etc), information about organizational determinations or other_____.

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1. Unless I specify otherwise on this form, I intend this disclosure to include all substance use disorder records maintained by MMM about me. I understand that my substance use disorder records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time, or as described in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.
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Member signature or Designated Legal Representative/Guardian signature X	Date (MMDDYYYY)

Designated Legal Representative/Guardian —
Complete this section only if you have documentation supporting Legal Representation.

If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following:

- A copy of a healthcare, general or Durable Power of Attorney.

OR

- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

Please complete the following:

Legal representative (print full name)		Legal relationship to member	
Legal representative street address	City	State	ZIP code
Signature X		Date (MMDDYYYY)	

Please return the completed form to:
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