MASS **ADVANTAGE**

P.O. Box 830059
Birmingham, AL 35283

Authorization to Release Substance Use Disorder (SUD) Protected Health Information (PHI)

Mail or fax or this completed form and any relevant documentation to Mass Advantage at 774-701-1416

Section 1	**Member Information**	
First Name	Middle Name	Last Name
Member ID	DOB	
Mailing Address (include Apt. #)		
City	State	Zip
Email	Phone Number	

Section 2 Amount and Kind of Information

I authorize Mass Advantage to share my Substance Use Disorder (SUD) information as follows:

☐ All of my SUD information

☐ Only the following SUD records (be as specific as possible; for example, discharge summary only, labs only, paid claims only, authorizations only:

_____

The dates of the records subject to this authorization are _____ through _____

Section 3 Who Receives this Information

I authorize Mass Advantage to share my SUD information as specified in this form with the following individual or entity. Please select which applies:

☐ Non-Treating Provider ☐ Provider

☐ Other (please specify): _____

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Be as specific as possible here:		
Individual Name*		
Entity Full Name**		
Mailing Address (include Apt. #)		
City	State	Zip
Phone Number	Email	

*If you would like us to share your information with more than one individual or entity, please provide the same information for the additional recipients in Section 9.

**If the entity is non-treating provider entity (e.g., law firm, life insurance, PPS), please indicate a specific individual's name to whom the information will be released.

Section 4 Why is this Information Being Released

I authorize Mass Advantage to share my SUD information for the following purpose (be as specific as possible):

_____

_____

_____

Section 5 Expiration and Revocation

If an expiration date or event is not provided, this form will expire no later than 24 (twenty-four) months from the date it is signed.

☐ Authorization should expire on _____ (MM/DD/YYYY)

or _____

☐ Once the following event occurs: _____

Right to Revoke: I may cancel this authorization form at any time. If I wish to do so, I can write to Mass Advantage's Compliance/Privacy Office either by mail: Mass Advantage, P.O. Box 830059, Birmingham, AL 35283 or by fax at 774-701-1416. I understand it will not affect any action Mass Advantage took before they received my cancellation request.

Section 6 | Important Information I Need to Know

My signature below means that I understand my SUD records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164. My SUD information cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Section 7 | Member's Signature or Authorized Party's Signature

You must sign this form if you are the member or the member's legal representative.

If you are the adult member or the authorized part signing this form, please check the correct box to indicate your relationship to the member. Sign and print your name, and don't forget to include the date.

Please Note: if you are the member signing this form, your name in this section must match the name used in Section 1.

If you are signing this form on behalf of the member, you must provide the supporting documentation authorizing you to represent the member.

☐ Spouse ☐ Domestic Partner ☐ Friend ☐ Child

☐ Relative _____ ☐ Other _____

_____ _____

Signature Date

_____

Print Name

Section 8 | Where to Send the Completed Form

Return this completed form and any relevant documentation to Mass Advantage at:
Mass Advantage, P.O. Box 830059, Birmingham, AL 35283
Fax: 774-701-1416

Section 9 | Additional Recipient Information (Related to Section 3)

Please select which applies:

☐ Non-Treating Provider ☐ Provider

☐ Other (please specify) _____

Be as specific as possible here:

Individual Name*

Entity Full Name**

Mailing Address (include Apt. #)

City	State	Zip

Phone Number	Email

Please select which applies:

☐ Non-Treating Provider ☐ Provider

☐ Other (please specify) _____

Individual Name*

Entity Full Name**

Mailing Address (include Apt. #)

City	State	Zip

Phone Number	Email

**If the entity is non-treating provider entity (e.g., law firm, life insurance, PPS), please indicate a specific individual's name to whom the information will be released.