

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



Contact Information

Mail this completed form and any relevant documentation to Mass Advantage,
P.O. Box 830059, Birmingham, AL 35283 or to fax 774-701-1416.

1 Member Information

First Name	Middle Initial	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of Birth (mm/dd/yyyy)	Mass Advantage ID#	
<input type="text"/>	<input type="text"/>	
Mailing Address (include Apt. #)		
<input type="text"/>		
City	State	Zip
<input type="text"/>	<input type="text"/>	<input type="text"/>
Phone Number	Email	
<input type="text"/>	<input type="text"/>	

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

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):

Be as specific as possible here:

Individual or Entity Full Name

Mailing Address (include Suite or Apt. #)

City

State

Zip

<input type="text"/>	<input type="text"/>	<input type="text"/>
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Phone Number

Email

<input type="text"/>	<input type="text"/>
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*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 8.

**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.

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):

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.

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.

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.

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

8 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 or Entity Full Name

Mailing Address (include Suite or Apt. #)

City

State

Zip

<input type="text"/>	<input type="text"/>	<input type="text"/>
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Phone Number

Email

<input type="text"/>	<input type="text"/>
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Please select which applies:

Non-Treating Provider Provider

Other (please specify)

Be as specific as possible here:

Individual or Entity Full Name

Mailing Address (include Suite or Apt. #)

City

State

Zip

<input type="text"/>	<input type="text"/>	<input type="text"/>
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Phone Number

Email

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