AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

This authorization is: ☐ Initiated by the insured ☐ Requested by MCS

Insured Name: ______________________________ Date of Birth: ______________

Contract Number: ______________________________

Address: ______________________________

Telephones: Home: ______________ Cellular: ______________ Other: ______________

(A) I hereby authorize MCS to:

I. Use and/or disclose the Protected Health Information described below. I understand that otherwise, this information would be protected and not subject to any use and/or disclosure. I understand that this information was compiled from MCS and/or its business associates' data banks. (Please select the applicable option(s))

☐ Subscriber's complete record ☐ Surgical Procedure (Specify ______________________)
☐ Pre-authorizations ☐ Other (Specify ______________________)

II. Grant permission to act on my behalf to (if applicable):

☐ Change my address ☐ Change my PCP

(B) I authorize the following persons (or class of persons), at the following address, to receive, use and/or disclose my Protected Health Information:

Name: ______________________ Name: ______________________

Address: ______________________ Address: ______________________

Telephone: ______________________ Telephone: ______________________

(C) My Protected Health Information will be used and/or disclosed for the following purpose: (Please, select one option).

☐ At the request of the individual ☐ Legal Procedure ☐ Other (Specify: ______________________

(D) This authorization expires (specify an expiration date or event): ______________________

(E) If you are the insured authorized representative, please select the option below that provides such authority and present a copy of the document:

☐ Power of attorney ☐ Certification from the physician ☐ Other: ______________________

I understand that I have the right to revoke this authorization at any time. I understand that my decision to revoke this authorization will be presented in writing, and will be submitted to MCS, where my Protected Health Information is maintained. I understand that if I decide to revoke this authorization, it will not be effective to the extent that the individuals that I have authorized to use and/or disclose my Protected Health Information have taken action in reliance thereon, or the authorization was obtained as a condition of obtaining insurance coverage, or other law provides the insurer with the right to contest a claim under the policy or the policy itself. I understand that I am not obligated to sign this authorization whenever the use and/or disclosure are requested by MCS. If I decline signing this document, my eligibility for coverage or benefits will not be affected. I understand the possibility that the Protected Health Information disclosed with this application might be re-disclosed by the receiver. If the re-disclosure is done to someone who is not obligated to comply with federal privacy protection laws, such information could no longer be protected.

______________________	______________________	______________
Insured or Authorized Representative	Signature	Date
______________________	______________________	______________
Witness (If necessary)	Signature	Date

General Instructions to Complete the Authorization for Use and/or Disclosure of Protected Health Information Form

- The Authorization for Use and/or Disclosure of Protected Health Information Form is used by the insured to authorize a person or entity with access to Protected Health Information.

- The Authorization may be submitted by the insured or by MCS. In your case, check "Initiated by the subscriber".

- Include name, date of birth, contract number, address, and a phone number. **Provide copy of a signed ID (example: driver's license, voter's card, passport) to validate your signature on the form**.

(A)- Select or specify the information that you want to use and/or disclose; and/or the permit to be granted.

(B)- Include the name of the person, people, or name of the Institution that you want to authorize, with the complete address. **Provide copy of a signed ID (example: driver's license, voter's card, passport) of the person, people, or institution representative been authorized.**

(C)- Select how the Protected Health Information will be used. **If you do not wish to provide information about using the PHI, please select "At the request of the individual".**

(D)- Specify an expiration date or event for the authorization **(example: "12/31/2050", valid while insurance policy is active".**

(E)- In order to act as the insured's representative, present a legal Power of Attorney, Medical Certificate, and/or other document indicating that you are responsible for the subscriber's health care. **You must provide a copy of one of these documents, and a signed ID. The Social Security benefits representation document is not accepted for processing this form.**

Important:

- The signature and the date on this Authorization form are required for the document to be valid.
- If the Authorization form is not completed correctly, it becomes invalid, and therefore it cannot be recorded. This situation may cause delays in our service.

Please return this form and request assistance for recording this document at your nearest MCS Service Center
MCS Call Center 787-758-2500 (Metro Area), 1-866-627-8183 (Toll Free) and TTY 1-866-627-8182
Service Hours from Monday through Sunday 8:00 a.m. to 8:00 p.m.

MCS complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. MCS cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. MCS 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-866-627-8183 (TTY: 1-866-627-8182). ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-627-8183 (TTY: 1-866-627-8182). 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-866-627-8183 (TTY: 1-866-627-8182).

Confidentiality Notice: This communication is privileged and confidential, and/or protected health information (PHI) or electronic protected health information (ePHI), and may be subject to protection under the law, including HIPAA. This communication is intended for the sole use of the individual or entity to whom it is addressed. If you are not the intended recipient, be advised that any use, disclosure, distribution, copying, or action taken in reliance on the contents of this communication is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for its return.