AUTHORIZATION FOR USE OR DISCLOSURE
OF PROTECTED HEALTH INFORMATION (PHI)
HIPAA Privacy Policy Form – For PHI Related to MPC Benefit Plans

MEMBER NAME: _____ **SSN OR EMPLOYEE ID**: _____

PATIENT NAME: _____ **DATE**: _____

I hereby authorize the Marathon Petroleum Company LP sponsored plans specified below to use or disclose personal health information ("PHI") about the above-named patient to the following persons/organizations:

_____

_____

___ Health Plan
___ Dental Plan
___ Vision Plan
___ Health Care Flexible Spending Account Plan (HCFSA) Plan
___ Retiree Health Plan
___ Pre-65 Retiree Dental Plan
___ Pre-65 Retiree Vision Plan
___ Employee Assistance Program
___ Exchange Health Reimbursement Account (EHRA)

The information to be disclosed shall include the following PHI under these Marathon Petroleum Plan(s):

___ Claim Information
___ Medical Records *(including diagnosis)*
___ Treatment Information
___ Other: _____

This PHI may be used or disclosed for the following purpose(s):

_____

_____

_____

Please Review Carefully:

- You may request to inspect and/or copy the PHI to be used or disclosed under this Authorization. However, for PHI created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.
- This Authorization is voluntary and you may refuse to sign it. Your refusal to sign will not affect your ability to obtain treatment or your eligibility for benefits.
- You may revoke this Authorization at any time by sending a written notification to the MPC HIPAA Privacy Officer at the address below. Your notice to revoke Authorization will not apply to actions taken by the requesting person or entity prior to the date your written request to revoke Authorization is received.
- The information that is used or disclosed pursuant to this Authorization may be redisclosed by the receiving person or organization and, upon such redisclosure, no longer be protected by federal privacy laws.

Authorization:

I authorize the use and disclosure of PHI as listed above and acknowledge I have been given an opportunity to deny this authorization. I understand that this authorization will expire one hundred eighty (180) days from the date below.

Printed Name: _____ **Relationship**: _____

Signature: _____ **Date**: _____

Return completed form to:

MPC Benefits
Attn: HIPAA Privacy Officer
539 South Main Street
Findlay, OH 45840
privacy@marathonpetroleum.com