MEMBER'S AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Member: By signing this form, you give Central California Alliance for Health permission to use or disclose your protected health information for the specific purpose described below.

**** YOU MAY REFUSE TO SIGN THIS FORM ****

Member Information

Name: _____
Address: _____
Telephone: _____
Member ID Number: _____
Member Date of Birth: _____

Please read the following statements carefully

No Conditions: If you decide not to sign this authorization, it will not affect enrollment in our health plan or your eligibility for health benefits.

Effect of Signing This Form: The protected health information described below may be re-disclosed to a third party that is not a health care provider or a health plan covered under federal privacy laws.

Member's Right of Access: You have the right to review and obtain a copy of your protected health information maintained by Central California Alliance for Health (the Alliance) in any of the following records:

- Record of your enrollment with the Alliance.
- Your claims history with the Alliance, including payments records.
- Case management or medical management records.

Exceptions: The Alliance will not release any information we have compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding, any information restricted under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. § 263A), psychotherapy notes, and certain other records.

Right to Revoke: You may revoke this authorization at any time by giving written notice to the Privacy Official listed below. Revoking this authorization will *not* affect any actions we may have taken before we receive your revocation notice.

Specific Authorizations: The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:

☐ Alcohol/Drug Treatment ☐ Mental Health Information ☐ HIV-Related Information

Description and Amount of the Health Information to Be Disclosed:

_____

_____

Purpose of the Authorization Request:

_____

Health Information may be released to the following:

Name/Agency: _____
Address: _____
Telephone: _____
Fax Number: _____

☐ Check if giving permission to speak to multiple person(s)/agency(s)
(if checked, complete page 3)

This authorization will expire:

☐ On this date:
☐ Or, in case of the following event: _____

Member's Signature:

I, _____, have read and understood the contents of this form. I understand that by signing this form, I give the Alliance permission to use or disclose protected health information about me. The information will only be used or disclosed for the purposes described, and only for the time period specified above.

Signature: _____ **Date**: _____

If you are completing this authorization form as a personal representative of the member, please provide:

Personal Representative's Name: _____
Relationship to Individual: _____
Personal Representative Signature: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION

Authorized Person(s)/Agency(s) Continued

Health Information may be released to the following:

Name/Agency: _____
Address: _____
Telephone: _____
Fax Number: _____

Health Information may be released to the following:

Name/Agency: _____
Address: _____
Telephone: _____
Fax Number: _____

Health Information may be released to the following:

Name/Agency: _____

Address: _____
Telephone: _____
Fax Number: _____

Health Information may be released to the following:
Name/Agency: _____
Address: _____
Telephone: _____
Fax Number: _____

Health Information may be released to the following:
Name/Agency: _____
Address: _____
Telephone: _____
Fax Number: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION