Health Net®

Authorization *for Disclosure of* Protected Health *Information*

Completion of this document authorizes the disclosure of your protected health information (PHI) as set forth below. This Authorization is required for the use or disclosure of your PHI beyond uses and disclosures for payment, treatment or health care operations to comply with the terms of federal HIPAA regulations 45 C.F.R. 164.508. A copy of this form is as valid as the original.

You hereby authorize Health Net to furnish to the person or entity identified below the health information described below.

Verification of individual whose information will be released – please print

Member name: _____ Member date of birth: _____

Health Net Identification #: _____ Member age (if minor): _____

Description of information to be released – Please print

This Authorization is limited to the following health information for (please specify date range): _____

Check applicable box(es):

☐ Application, Enrollment, Eligibility Information ☐ Account Information ☐ Claims/Explanation of Benefit Information

☐ Pharmacy Information ☐ Prior Authorization ☐ Medical Records ☐ Premium Billing/Payment Information

☐ I authorize Health Net to release information that may include record of: (select all that apply)
☐ drug treatment ☐ alcohol treatment

☐ I authorize Health Net to release confidential HIV/AIDS-related information, including AIDS-related complex (ARC) or confidential communicable disease-related information for the purpose of: _____

☐ Other Information (please describe below):

_____

Person or entity to receive information

Name: _____

Company (if applicable):_____

Address: _____

City: _____ State: _____ ZIP: _____ Phone number: _____

Expiration of Authorization

This Authorization will expire _____, (not to exceed one year in Arizona and California, 180 days in Washington and two years in Oregon). (mm/dd/yy)

Important Information

- Information disclosed based on this Authorization could be re-disclosed by the recipient and may no longer be protected by federal privacy regulations.
- You may revoke this Authorization at any time in writing, by sending it to the Health Net Privacy Office, Attention Director, Information Privacy, PO Box 9103, Van Nuys, California 91409 as set forth in Health Net's Notice of Privacy. Your revocation will be effective upon receipt, but will not be effective to the extent that Health Net or others have acted in reliance upon this Authorization.
- Neither payment, enrollment nor eligibility for benefits will be conditioned on your providing or refusing to provide this Authorization. This restriction does not apply if Health Net is seeking to obtain information in connection with your eligibility or enrollment in Health Net when you are not already a member or to obtain information required for payment of a specific claim for benefits.
- You have a right to receive a copy of this Authorization.

By signing this Authorization, you agree that you have read and understand the above information, and that your signature authorizes the disclosure of the information described above.

Signature of member, personal representative, parent/guardian who is authorizing the disclosure:

_____ Date: _____

Relationship – description of authority if the person signing is other than the member whose information is disclosed:

_____

If this Authorization is signed by a personal representative of the member, we will require verification of the individual's authority to act as personal representative before any PHI is disclosed pursuant to this Authorization.

If this Authorization is signed by a parent/guardian of a minor member, we may require additional information, including a separate Authorization signed by the minor member, before disclosing any PHI regarding the member.