PacifiCare®

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information**. Failure to provide *all* information requested may invalidate this Authorization.**

USE AND DISCLOSURE OF HEALTH INFORMATION

I, (Member's Name) _____ hereby authorize the use or disclosure of my health information as follows:

Name of Person/Organizations I authorize to *use or disclose* my information[1a]: _____

Name of Person/Organizations I authorized to *receive* my information[1b]: _____

The reason for the authorization is to[2]: _____

This Authorization applies to the following information: (select from the following)[3]:

- ❑ All health information pertaining to my medical history or care.

  [Optional] Except: _____

- ❑ Only the following records or types of health information (including any dates):

  ❑ Claims status ❑ Authorization status ❑ Referral Status ❑ Other _____

  Lists dates of service for which you are authorizing release of your information: _____

- ❑ An authorization to release health information relating to psychotherapy notes, drug/alcohol treatment, HIV and genetic testing **must be separate** from authorization to release other types of health information. Authorization to release this information can be noted in the "Other" section above.

EXPIRATION

This authorization will expire on (check one): ❑ Insert Date _____

❑ When I terminate from PacifiCare Health Plan

SIGNATURE

_____ _____

PRINT MEMBER NAME PACIFICARE ID#

_____ _____

MEMBER SIGNATURE DATE

If signed by someone other than the member (such as guardian or conservator), please complete the following:

_____ _____

PERSONAL REPRESENTATIVES PRINTED NAME RELATIONSHIP

_____ _____

PERSONAL REPRESENTATIVES SIGNATURE DATE

If you have authorized the disclosure of your health information to someone, who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.

[1a]This is the name of the person or organization that currently holds the information (for example, PacifiCare) should be inserted here.
[1b]This is the name of the person or organization that is requesting access to your health information.

[2]The statement "at the request of the individual " is a sufficient description of the purpose when the individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.

[3]This form may not be used to release both psychotherapy notes and other types of health information *(see 45 CFR § 164.508(b)(3)(ii))*. If this form is being used to authorize the release of psychotherapy notes, a separate form must be used to authorize release of any other health information.

[4]If authorization is for use or disclosure of PHI for research, including the creation and maintenance of a research database or repository, the statement "end of research study," "none" or similar language is sufficient.

[5]Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures *(see 45 CFR § 164.508(d)(1), (e)(2))*.

[6]If any of the exceptions to this statement, as recognized by HIPAA apply, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.

NOTICE OF RIGHTS AND OTHER INFORMATION

- I may refuse to sign this authorization.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and sent to the address on the back of your membership card, attention: Correspondence Team.
- My revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.[5]
- I understand that PacifiCare will not condition treatment, payment, enrollment or eligibility for benefits on my providing or refusing to provide this authorization.[6]
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
- I may inspect or obtain a copy of the health information that I am being asked to use or disclose.
- If this box ☐ is checked, the Requester will receive compensation for the use or disclosure of my information.

SecureHorizons® FROM PacifiCare

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- ❑ All health information pertaining to my medical history or care.

  [Optional] Except: _____

- ❑ Only the following records or types of health information (including any dates):

  ❑ Claims status ❑ Authorization status ❑ Referral Status ❑ Other _____

  Lists dates of service for which you are authorizing release of your information: _____

- ❑ An authorization to release health information relating to psychotherapy notes, drug/alcohol treatment, HIV and genetic testing **must be separate** from authorization to release other types of health information. Authorization to release this information can be noted in the "Other" section above.

EXPIRATION

This authorization will expire on (check one): ❑ Insert Date _____

❑ When I terminate from Secure Horizons Health Plan

SIGNATURE

_____ _____

PRINT MEMBER NAME SECURE HORIZONS ID#

_____ _____

MEMBER SIGNATURE DATE

If signed by someone other than the member (such as guardian or conservator), please complete the following:

_____ _____

PERSONAL REPRESENTATIVES PRINTED NAME RELATIONSHIP

_____ _____

PERSONAL REPRESENTATIVES SIGNATURE DATE

If you have authorized the disclosure of your health information to someone, who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.

[1a]This is the name of the person or organization that currently holds the information (for example, Secure Horizons) should be inserted here.
[1b]This is the name of the person or organization that is requesting access to your health information.

[2]The statement "at the request of the individual " is a sufficient description of the purpose when the individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.

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- My revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.[5]
- I understand that Secure Horizons will not condition treatment, payment, enrollment or eligibility for benefits on my providing or refusing to provide this authorization.[6]
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
- I may inspect or obtain a copy of the health information that I am being asked to use or disclose.
- If this box ☐ is checked, the Requester will receive compensation for the use or disclosure of my information.