Authorization for Use or Disclosure of Protected Health Information (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific):_____

_____

_____

Person or organization authorized to received the health information: _____

Describe each purpose of the requested use or disclosure (please be specific): _____

_____

_____

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: _____

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

Continue on page 2.

RESTRICTIONS:

I understand that the health information used or disclosed as a result of my signing this authorization may not be further used or disclosed by the recipient unless another authorization is obtained from me or unless such use or disclosure id specifically permitted or required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____

If Authorized Representative (please include appropriate documentation):

Print Name: _____ Relationship to Member: _____

Basis for legal authorization by an Authorized Representative: _____

_____

_____