CENTRAL HEALTH PLAN OF CALIFORNIA

HIPAA AUTHORIZATION FORM
FOR RELEASE OF PROTECTED HEALTH INFORMATION

SECTION A: Individual Authorizing Use and/or Disclosure.

Member Name: _____

Member ID #: _____

Address: _____

Date of Birth: _____

Phone Number: _____

SECTION B: The Use and/or Disclosure being Authorized.

PHI to Be Used and/or Disclosed: **{Specifically describe the PHI to be used and/or disclosed; and include dates of service, provider names, etc.}**

_____

_____

[ ] Check if this authorization is for psychotherapy notes.
If this authorization is for psychotherapy notes, you must *not* use it as an authorization for any other type of protected health information (PHI).

Entities or Persons Authorized to Use or Disclose**: {Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), including CHPC, who are authorized to make use of and/or to disclose the PHI described above}**
[x] Central Health Plan of California (CHPC)

_____

_____

Entities or Persons Authorized to Receive**: {Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations), including CHPC, who are authorized to receive, and subsequently use and/or disclose the PHI described above}**

_____

_____

{Please choose only one box}
[ ] CHPC **IS** authorized to release Member information regarding: AIDS/HIV and other communicable disease; mental health information (including behavioral health and psychiatric care); alcohol/drug abuse treatment; genetic testing information.
[ ] CHPC **IS NOT** authorized to release Member information regarding: AIDS/HIV and other communicable disease; mental health information (including behavioral health and psychiatric care); alcohol/drug abuse treatment; genetic testing information.

Purpose of this authorization: **{Please select all that apply}**
[ ] At the request of the CHPC Member
[ ] To help with coordination of the Member's health care
[ ] For coverage or payment reasons
[ ] I make health decisions for the member
[ ] The member died and I take care of the assets
[ ] Other (please specify):_____

SECTION C: Expiration and revocation.

Expiration Date of Authorization
This authorization will expire: **{Please choose only one box}**
[ ] 12 months from the date of my signature **OR**
[ ] On the following date or event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized): **{Please specify}**

I, the member (or person acting on behalf of the member), have had full opportunity to read and consider the contents of this authorization, and I understand that by signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information, as described in this form. I, the member (or person acting on behalf of the member), agree to the following:

- **Right to Revoke:** If I want to cancel this authorization before it expires, I must submit a written notice to CHPC at the address listed below. It is understood that information released prior to my written cancellation was made at my request and with my consent.
- **Potential to Redisclose:** I understand that the information disclosed by this authorization could be re-disclosed by the person receiving it and is no longer protected by federal or state legal privacy requirements. CHPC, its affiliates, its employees, and officers are not legally responsible or liable for the re-disclosure of the information indicated on this authorization.
- **Eligibility for Benefits Unaffected:** I understand that I do not have to sign this Authorization, and my decision not to sign does not affect eligibility for benefits,

treatment or payment. I understand that CHPC and/or its contracted providers may, under certain circumstances, require a separate Authorization for purposes not related to this Authorization.

_____
Signature of Member

_____
Date

_____
Printed Name of Member

If this authorization is signed by a personal representative, i.e., **with Legal Authority** to act on behalf of the individual, complete the following:

_____
Personal Representative's Name

_____
Date

_____
Signature of Personal Representative

_____
Relationship to the Member

Please send this form to:

Central Health Plan of California
Attention Member Services
PO Box 14244
Orange, CA 92863

Please contact Central Health Plan at 1-866-314-2427 if you have any questions or comments.

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

INSTRUCTIONS FOR COMPLETION OF THE CENTRAL HEALTH PLAN OF CALIFORNIA GENERAL MEMBER AUTHORIZATION FORM

Section A: Individual Authorizing Use and/or Disclosure

Please complete all items of information in this section to include your Full Name and Member ID Number exactly as they appear on your Identification Card, your current address and a telephone number where you may be contacted.

Section B: The Use and/or Disclosure Being Authorized

- **Protected Health Information (PHI) to be Used and/or Disclosed:** Enter the specific protected health information that you want used or disclosed. For example, if you want your claims processing, claims payment and enrollment information to be disclosed to a third party acting on your behalf, you may want to enter the following narrative in these spaces: ***"All information concerning claims payment, denial of coverage, the status of pending claims, billing status or any other information needed to respond to a normal customer service inquiry on my behalf."***

- **If Psychotherapy Notes is checked, authorization will be VOID for any and all other uses & disclosures.**

- **Entities or Persons Authorized to Use or Disclose:** This form authorizes CENTRAL HEALTH PLAN OF CALIFORNIA to disclose this information to another third party acting on your behalf. If you are also authorizing parties other than CENTRAL HEALTH PLAN OF CALIFORNIA to disclose this information, please enter the specific names of those parties in these spaces.

- **Entities or Persons Authorized to Receive:** Please enter the name(s) of the person(s) or organization(s) that you are authorizing to access your PHI and act on your behalf. For example, if you are authorizing your spouse or any other individual to act on your behalf, enter his/her name in these spaces. If you are authorizing an organization (such as a broker, consultant, or your company's Human Resources Department) to act on your behalf, enter the specific name of the organization in these spaces: **Examples:** ***"ABC broker" or "Human Resources Department, XYZ Company"***

  These are example entries only. Please enter the actual names of the persons or organizations you are authorizing to receive PHI and act on your behalf.

- **Purpose of this Authorization:** There are two blocks in this section. Please complete **only one** of these blocks per the following instructions:

If you check the "At request of individual" block, you are authorizing the person(s) or organization(s) you specified in the previous entry to receive your PHI and act on your behalf for any purpose permitted by the HIPAA Privacy Rule to include claims status and payment inquiries, appeals, premium payment inquiries and other policy service purposes. Checking this block is recommended because it will give your authorized representative and CENTRAL HEALTH PLAN OF CALIFORNIA Member Services maximum flexibility to work together to respond to and resolve your policy service questions and needs. **If you check this block, no further entries are required in this section**.

If you check the "For the following purposes:" block, you must enter a specific purpose for the authorization in the spaces provided. For example, if you only want the person(s) or organization(s) you are authorizing to receive your protected health information and act on your behalf to handle a claims appeal for you, you would enter ***"To appeal a claim determination"*** or something similar in that block. If you only want them to be able to check claims processing or payment status on your behalf, you would enter ***"To check claims processing or payment status"*** in that block.

If you use this block, you need to know that CENTRAL HEALTH PLAN OF CALIFORNIA will only be able to discuss information pertaining to the purposes you specified with your authorized representative and nothing else.

Section C: Expiration and Revocation

- **Expiration:** There are two blocks in this section. Please complete **only one** of these blocks per the following instructions:

  If you want the authorization to expire on a certain date, please check the first block and enter that date in month, day and year order as specified *(**Example**: **12/31/2004**)*. **If you enter a date in this space, no further entries are required in this section.**

  If you want the authorization to expire when a future event occurs, please enter that event in the spaces provided for this block. An example entry is ***"Upon the end of my coverage with CENTRAL HEALTH PLAN OF CALIFORNIA."***

Section D: Individual's Signature

Please print your name in the first space and then sign and date it in the spaces provided. If your legal representative or guardian signs the form on your behalf,

your legal representative or guardian must print his/her name, sign and date the form and indicate his/her relationship to you in the spaces provided.

Please keep a copy of this authorization form for your records.