Authorization for PHP (HMO SNP) to Request My Health Information

Note to Applicant: *By completing and signing this form, you authorize PHP to request health information about you from your health care provider to verify eligibility for PHP. This form also authorizes your provider to disclose health information about you to PHP. PHP is an HMO plan with a Medicare contract. Enrollment in PHP depends on contract renewal.*

Name of Applicant: _____
Please Print

I hereby authorize PHP to contact my health care provider or his/her/its office listed below to request the release of information about me regarding my HIV and/or AIDS condition, a qualifying condition for enrollment in the PHP health plan. Also, I specifically authorize PHP to request the release of HIV test results to PHP. I authorize my health care provider to release information regarding my HIV and/or AIDS condition to PHP.

The purpose of this request is to allow PHP to determine my eligibility for enrollment into the health plan, which is a Medicare Advantage Prescription Drug Special Needs Plan. This Authorization expires one year from the date below. I may refuse to sign this Authorization, however, if I do, I understand that PHP may not be able to confirm my eligibility for the health plan and therefore unable to enroll me.

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of. I have a right to receive a copy of this Authorization. I understand that information disclosed pursuant to this Authorization could be redisclosed by the recipient pursuant to state and federal law.

Also, I may revoke this authorization at any time, but I must do so in writing and submit it to Attn: Eligibility and Enrollment, PHP, P.O. Box 46160, Los Angeles, CA 90046. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

Name of Provider: _____
Please Print

Provider's Address: _____
Street Address, City, State, Zip

Provider's Telephone Number: _____

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this form means that I have read and understand the contents of this form. If signed by an authorized individual, this signature certifies that 1) this person is authorized under State law to complete this form and 2) documentation of this authority is available upon request by PHP.

Signature:	**Today's Date:**

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone Number: (_____) _____-_____

Relationship to Enrollee: _____