Authorization for Use or Disclosure of Health Information

Completion of this document authorizes the disclosure and/or use of health information about you. PHC California is a managed care plan with a California Medi-Cal contract.

Member Name: _____

Use and Disclosure of Health Information

I hereby authorize the physicians; health care providers; and health care entities, including any physician or health care provider of that entity, listed in the table below, to release the health information checked below to PHC California:

Provider Name	Address (if known)	City	State	Zip

☐ All health information pertaining to my medical history, mental or physical condition and treatment received ***OR***

☐ Only the following records of the types of health information (including any dates) as follows: _____

_____

_____

In addition, I specifically authorize release of: *(check as appropriate)*

☐ Mental health treatment information

☐ HIV test results

☐ Alcohol/drug treatment information

Purpose

Purpose of requested use or disclosure: ☐ member request ***OR*** ☐ other (specify):

_____

Member Name: _____

Expiration

This Authorization expires at the time your membership in PHC California terminates.

My Rights

I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or eligibility for benefits except as allowed by law.

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing and submit it to Attn: Member Services, PHC California, 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.

I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient as allowed by law. Such re-disclosure is in some cases not protected by State law and may no longer be protected by federal confidentiality law (HIPAA).

Signature

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 PHC California.

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:** _____	