AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Fill out **ALL** sections of this form to allow CalOptima Health to release your protected health information (PHI) to another person or agency. This form is **ONLY** to release the information. It will not allow anyone to make health care decisions for you.

SECTION A: Member Information

Last Name: _____ First Name: _____

CIN: _____ Date of Birth: _____ *mm/dd/yyyy*

Address: _____

Street/Unit Number *City* *State* *Zip Code*

Best phone number to contact you: _____

Instructions: Mark **X** inside the box next to your selected option.

SECTION B: Information That Can Be Released

I allow CalOptima Health to release:

☐ Any and all of my PHI

☐ Only release the following: (list what you allow):

_____

_____

I allow the release of PHI about:
(Initial if any of the below boxes are checked)

☐ Mental health treatment Initial:_____
☐ Alcohol / drug treatment Initial:_____

NOTE: These details will not be released unless you approve first.

SECTION C: Purpose of Authorization

I am releasing this information for:

☐ Personal Use ☐ Legal

☐ Insurance ☐ Other (please specify.): _____

SECTION D: Person(s) or Agency Allowed to Get PHI

I allow CalOptima Health to release my PHI to the person or agency below. I know this authorization starts when I sign and return this form. The person getting the information must be 18 years of age or older.

Person /Agency's Name(s): _____

Relationship to Member _____ Phone: _____

SECTION E: My Rights

- I may stop this authorization at any time by sending a **written** notice to: CalOptima Health, Attn: Enrollment & Reconciliation, 505 City Parkway West, Orange, CA 92868.
- Notice to stop this authorization will not change how CalOptima Health used or released my PHI before getting my letter.
- The person or agency who gets my PHI from CalOptima Health may show it to others. In this case, my PHI may no longer be protected by HIPAA Privacy Rules.
- I do not have to fill out this form. Not filling out this form will not change my health care benefits or payment for my health care services.
- I have the right to look at or get a copy of my PHI that is being used or released by this authorization.
- I have the right to get a copy of this form.

SECTION F: End Date of Approval

This authorization for release of information to the named persons or agency will end on: _____ (specific date or event).

**** If an end date or event is not provided, the authorization will not be valid. ****

SECTION G: Signature

I understand that to process my request, a copy of valid government-issued identification (ID), a copy of documentation of legal authority, or a notarized signature must be attached with my request form.

By signing below, I have read this form and know what it means.

_____ _____

Signature of Member/Personal Representative Date

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name:_____ Relationship:_____

CalOptima Health reserves the right to request legal documentation (e.g., birth certificate, court order) from the parent/guardian signing on behalf of a dependent member.

Personal Representatives Only: What rights do you have to request health information?

Print Name: _____

- ☐ Conservator
- ☐ Executor of Will
- ☐ Administrator of Estate
- ☐ Medical Power of Attorney
- ☐ Other_____

NOTE: You must attach legal documentation to verify that you are the conservator, executor of a decedent's will, or have medical decision-making authority for the individual.

Please mail this form to CalOptima Health, Attn: Enrollment & Reconciliation, 505 City Parkway West, Orange CA 92868, or fax it to **1-714-338-3104**.

STOP

For CalOptima Health Use Only:

Staff Name: _____ How was identity verified? In person/Phone

Signature: Date verified: