AUTHORIZATION FOR CALOPTIMA HEALTH TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI) TO ANOTHER PERSON OR ENTITY

Fill out **ALL** sections of this form to allow CalOptima Health to disclose your Protected Health Information (PHI) to another person or agency. This form **ONLY** allows for the disclosure of PHI you approve in Section B below that CalOptima Health holds. It will not allow anyone to make health care decisions for you.

SECTION A: Member/Patient Information

First Name: _____ Last Name: _____ Date of Birth:_____

Mailing Address: _____ City:_____ State:_____ Zip:_____

Phone Number:_____ CIN:_____

SECTION B: Information That Can Be Disclosed

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

I allow CalOptima Health to disclose the following Protected Health Information (PHI), dated

_____ to_____ :
(month/date/year) *(month/date/year)*

- ☐ Case management records
- ☐ Claims/billing records
- ☐ Customer service records
- ☐ Grievance & appeals records
- ☐ Health education/disease management records
- ☐ Referrals/authorizations records
- ☐ Pharmacy records
- ☐ Utilization management records

***The following sensitive information will only be shared if you select the applicable check box(es) and initial below.**

	Initial
☐ Psychotherapy notes **only**. These are notes that document or analyze the contents of a therapy session.**	_____
☐ Mental/behavioral health information	_____
☐ Substance use disorder information	_____
☐ Sexually transmitted infections information (including HIV/AIDS)	_____
☐ Sexual/reproductive health information (including family planning and gender affirming care)	_____
☐ Sexual or physical abuse information (including intimate partner violence)	_____
☐ For minors age 12+: Services related to infectious, contagious, communicable disease, or sexually transmitted disease	_____

*The above information will not be disclosed unless you approve with your initials.

**You must submit a separate authorization for disclosure of psychotherapy notes if you select to disclose other information in addition to psychotherapy notes.

SECTION C: Purpose of Authorization

I am allowing the disclosure of this information for:

☐ Personal Use ☐ Legal

☐ Insurance ☐ Other (please specify):_____

SECTION D: Person or Agency Allowed to Get Your PHI

I allow CalOptima Health to disclose my PHI to the person/entity below. This authorization starts when I sign and return this form. The person receiving the information must be 18 years of age or older.

Parent/Agency Name(s): _____

Relationship to Member/Patient: _____ Phone:_____

SECTION E: Your 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 that 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 but no later than one (1) year from when I sign and return this form).

****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:_____

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

Print Name: _____

☐ Conservator ☐ Medical Power of Attorney

☐ Executor of Will Other_____

☐ Administrator of Estate

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

Fax: 1-714-481-6457

STOP

For CalOptima Health Use Only:

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

Signature:_____ Date Verified:_____