Health Net Cal MediConnect Plan (Medicare-Medicaid Plan)

Authorization to Disclose Protected Health Information (PHI)

Notice to member:

- Completing this form will allow Health Net Community Solutions, Inc. (Health Net Cal MediConnect Plan (Medicare-Medicaid Plan)) to (i) use your health information for a particular purpose, and/or (ii) share your health information with the individual or entity that you identify on this form.
- You do not have to sign this form or give permission to use or share your health information. Your services and benefits with Health Net Community Solutions, Inc. will not change if you do not sign this form.
- Right to cancel (revoke): This authorization/consent form is subject to revocation at any time except to the extent that Health Net Community Solutions, Inc. or other lawful holder of your health information that is permitted to share it has already acted in reliance on it. If you want to cancel this Authorization Form, fill out the Revocation Form on the last page and mail it to the address at the bottom of the page.
- Health Net Community Solutions, Inc. cannot promise that the person or group you allow us to share your health information with will not share it with someone else.
- Keep a copy of all completed forms that you send to us. We can send you copies if you need them.
- Fill in all the information on this form. When finished, mail it to the address at the bottom of the second page.

Member information	
Member name (print):	
Member date of birth: _____ / _____ / _____	Member ID #:
I give Health Net Community Solutions, Inc. permission to use my health information for the purpose identified or to share my health information with the person or group named below. The purpose of the authorization is: ☐ to allow Health Net Community Solutions, Inc. to help me with my benefits and services, **or** ☐ to permit Health Net Community Solutions, Inc. to use or share my health information for _____.	

(continued)

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Authorization to Disclose Protected Health Information (PHI)

Person or group to receive information

Name (person or group):			
Address:			
City:	State:	ZIP:	Phone: ( ) –

I authorize Health Net Community Solutions, Inc. to use or share the following health information:

☐ **All of my health information (INCLUDING** genetic information, services or test results; HIV/AIDS data and records; mental health data and records (but not psychotherapy notes); prescription drug/medication data and records; and drug and alcohol data and records **(please specify any substance use disorder information that may be disclosed)** _____);

☐ All of my health information EXCEPT (check all boxes that apply):

- ☐ Genetic information, services or tests
- ☐ HIV/AIDS data and records
- ☐ Drug and alcohol data and records
- ☐ Mental health data and records (but not psychotherapy notes)
- ☐ Prescription drug/medication data and records
- ☐ Other: _____

Expiration of authorization

This authorization will expire on _____/_____/_____ (mm/dd/yy), validation good for a one year maximum. If no date is provided here, this authorization will expire in one year from the date listed below.

Member signature (member or legal representative sign here):	Date: _____/_____/_____

If you are signing for the member, describe your relationship below. If you are the member's personal representative, describe this below and send us copies of those forms (such as power of attorney or order of guardianship)._____

Mail completed form to:

Health Net, Inc. Privacy Office
PO Box 9103, Van Nuys, CA 91409

Phone: 1-855-464-3571 in Los Angeles or 1-855-464-3572 in San Diego (TTY: 711)
Fax: (818) 676-8314

(continued)

Authorization to Disclose Protected Health Information (PHI)

Additional individual person(s) or entity(ies) to receive information

Note: If you are consenting to disclose any substance use disorder records to a recipient that is neither a third party payor nor a health care provider, facility, or program where you receive services from a treating provider, such as a health insurance exchange or a research institution (hereafter, "recipient entity"), you must specify the name of an individual with whom or the entity at which you receive services from a treating provider at that recipient entity, or simply state that your substance use disorder records may be disclosed to your current and future treating providers at that recipient entity.

Name (individual or entity):			
Address:			
City:	State:	ZIP:	Phone: ( ) –

Name (individual or entity):			
Address:			
City:	State:	ZIP:	Phone: ( ) –

Name (individual or entity):			
Address:			
City:	State:	ZIP:	Phone: ( ) –

Mail completed form to:

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Revocation of Authorization to Disclose Protected Health Information

I want to cancel, or revoke, the permission I gave to Health Net Community Solutions, Inc. (Health Net Cal MediConnect Plan (Medicare-Medicaid Plan)) to use my health information for a particular purpose or to share my health information with a person or group.

Person or group that received the information			
Name (person or group):			
Address:			
City:	State:	ZIP:	Phone: ( ) –
Authorization signed date (if known): _____/_____/_____			

Member information	
Member name (print):	
Member date of birth: / /	Member ID #:
I understand that my health information (including, where applicable, my substance use disorder records) may have already been used or shared because of the permission I gave before. I also understand that this cancellation only applies to the permission I gave to use my health information for a particular purpose or to share my health information with the person or group. It does not cancel any other authorization forms I signed for health information to be used for another purpose or shared with another person or group.	
Member signature (member or legal representative sign here):	Date: _____/_____/_____
If you are signing for the member, describe your relationship below. If you are the member's personal representative, describe this below and send us copies of those forms (such as power of attorney or order of guardianship). _____	

Health Net Community Solutions, Inc. will stop using or sharing your health information when we receive and process this form. Use the mailing address below. You can also call for help at the number below.

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Fax: (818) 676-8314

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