Health Net®

Authorization *for Disclosure of* Protected Health *Information*

For use in California, Oregon and Washington

Completion of this document authorizes Health Net of California, Inc., Health Net Health Plan of Oregon, Inc., Managed Health Network, Inc., and/or Health Net Life Insurance Company, including affiliates and subsidiaries (collectively, "Health Net"), to use or disclose my protected health information (PHI) as set forth below.

Section I. Individual whose information will be disclosed

Name:	Member ID number:	Date of birth:
Address:		

Section II. Description of information to be disclosed

I authorize Health Net to disclose the following types of health information.

A. General description of health information (please select all that apply):

- ☐ Application, enrollment, membership, and eligibility records and information
- ☐ Claims/Explanation of Benefits/Evidence of Coverage records and information
- ☐ Pharmacy records and information
- ☐ Premium/payment/billing information and records
- ☐ Other information (please describe): _____

B. Additional description of sensitive information categories (please select all that apply):

You must complete this section to authorize the release of information and records regarding the following sensitive information categories:

- ☐ Drug or alcohol abuse diagnosis, treatment, prognosis, or referral
- ☐ HIV/AIDS (including AIDS-related complex (ARC)) or sexually transmitted diseases (STDs)
- ☐ Genetic testing
- ☐ Mental or behavioral health services

Section III. Purpose

I authorize Health Net to disclose the information identified above for the following purpose(s):

- ☐ At my request
- ☐ Other (please specify): _____

Section IV. Expiration of authorization

This authorization will expire on _____ (mm/dd/yy). If no date is provided, this authorization will expire in one year.

(continued)

Section V. Person or entity to receive information

I authorize disclosure of my health information as indicated above to the following:

Name:		Company (if applicable):	
City:	State:	ZIP:	Phone number: ( )
Name:		Company (if applicable):	
City:	State:	ZIP:	Phone number: ( )

Section VI. Important information

- Information disclosed based on this authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations, including HIPAA.
- I may revoke this authorization in writing by sending notice to the Health Net Privacy Office, Attention Director, Information Privacy, PO Box 9103, Van Nuys, CA 91409 as set forth in Health Net's Notice of Privacy Practices. My revocation will be effective upon receipt but will not be effective to the extent that Health Net or others have acted in reliance upon this authorization.
- Treatment, payment, enrollment, or eligibility for benefits are not conditioned on my providing or refusing to provide this authorization, unless I have not yet enrolled with Health Net and Health Net is seeking to obtain information in connection with determining my eligibility for benefits or enrollment, or unless Health Net is requesting the information for underwriting or risk rating purposes.
- I have a right to receive a copy of this authorization. A copy is as valid as the original.

Section VII. Acknowledgment

By signing this authorization, I acknowledge that I have read and understand the above information, and that my signature authorizes the disclosure of the information described above.

_____ _____

(Signature of member, personal representative or parent/guardian) Date

_____

(Printed name of member, personal representative or parent/guardian)

_____

(Relationship – description of authority to act on behalf of the member, if applicable)

If this authorization is signed by anyone other than the member, Health Net may require verification of the individual's authority to act on behalf of the member before any PHI is disclosed pursuant to this authorization. If this authorization is signed by a parent/guardian of a minor member, we may require additional information, including a separate authorization signed by the minor member, before disclosing any PHI regarding the minor member.