CALOPTIMA
A Public Healthcare Agency

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Explanation:

This "Authorization for Use or Disclosure of Health Information" is being requested of you to comply with the federal HIPAA Privacy Regulations, which protects the privacy of health information.

Authorization:

I, _____, hereby authorize _____, to use or disclose my health information as described below.
Name of facility or physician

Specific description of the health information that will be used or disclosed under this Authorization:

_____

_____

Person or organization authorized to receive the health information: _____

Specific description of each purpose of the requested use or disclosure: _____

_____

_____

_____

_____

Expiration Date/Event:

This Authorization shall become effective immediately and shall expire on: _____
Specific Date or Event

Right to Revoke: I understand that I have the right to revoke this Authorization in writing at any time. To revoke this Authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific Authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
1120 West La Veta Avenue
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this Authorization.

Restrictions:

I understand that health information used or disclosed as a result of my signing this Authorization may not be further used or disclosed by the recipient unless another authorization is obtained from me or unless such use or disclosure is specifically permitted or required by law.

Member Rights:

- I understand that I must receive a copy of this Authorization.
- I understand that I may receive additional copies of this Authorization.
- I understand that I may refuse to sign this Authorization.
- I understand that I may rescind this Authorization at any time.
- I understand that neither Treatment nor Payment will be dependent upon my refusing or agreeing to sign this Authorization.

Additional Copies

Additional copies received: o Yes o No Initial _____ Quantity _____

Signature:

I acknowledge receiving a copy of this Authorization o Yes o No

Signature of Member: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative: _____

_____

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