

Authorizations To Use/Disclose Protected Health Information

**Authorization for Disclosure of Health Information Form**

(1) I hereby authorize Health Net to disclose the following information from the health records of

Member Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

\_\_\_\_\_ Member ID# \_\_\_\_\_

covering the period(s) of healthcare

From(date) \_\_\_\_\_ To(date) \_\_\_\_\_

From(date) \_\_\_\_\_ To(date) \_\_\_\_\_

(2) Information to be disclosed

complete health record(s)  discharge summary

history & physical examination  progress notes

claim information  laboratory tests

benefit information  other

(please specify) \_\_\_\_\_

Check if disclosure shall include information relating to:

Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection

Behavioral health services/psychiatric care

Treatment for alcohol and/or drug abuse

If boxes are not checked, no such information shall be released.

(3) This information is to be disclosed to \_\_\_\_\_

for the purpose of \_\_\_\_\_

(4) Unless otherwise revoked, this authorization shall become effective immediately and shall remain in effect until (date) \_\_\_\_\_, event,

condition: \_\_\_\_\_

month/day/year

(5) I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization.

(6) Additional Copy. I understand that I have a right to receive a copy of this authorization upon my request.  
Copy requested and received: Yes\_\_\_\_\_ No\_\_\_\_\_ \_\_\_\_\_

Member Initial

(7) Health Net, its employees and officers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed:

Member \_\_\_\_\_

Date \_\_\_\_\_

or Legal Representative \_\_\_\_\_

Relationship to Member \_\_\_\_\_

Date \_\_\_\_\_

Signature of Witness \_\_\_\_\_

Relationship to Member \_\_\_\_\_

Date \_\_\_\_\_