AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

EXPLANATION

This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the federal HIPAA privacy regulations, 45 C.F.R. § 164.508.

AUTHORIZATION

I hereby authorize Health Net to furnish to [*name of person*] ____________________________ medical records and information pertaining to [*name of patient*] ____

____

This authorization is limited to the following medical records and type of information:

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USES

Health Net may use the medical records and type of information authorized only for the following purposes:

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DURATION

This authorization shall become effective immediately and shall remain in effect until [*date*] ____.

NOTICE

Information used or disclosed pursuant to an authorization may be subject to redisclosure by the recipient and no longer protected by the federal health information privacy regulations.

MY RIGHTS

I may revoke this authorization at any time as set forth in Health Net's Notice of Privacy Practices.

Neither payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. This restriction does not apply if Health Net is seeking to obtain information in connection with my eligibility or enrollment in Health Net when I am not already a member or to obtain information required for payment of a specific claim for benefits.

I have a right to receive a copy of this authorization.

SIGNATURE

Date:________________________________

Signature: ___________________________

[*patient/representative/spouse/financially responsible party*]

If signed by other than patient, indicate relationship: _______________________

Witness: ____