

Authorization to Use and Disclose Health Information

NOTICE TO MEMBER:

- Completing this form will allow Health Net of California, Inc. 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 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 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 page 3 and mail it to the address at the bottom of the page.
- Health Net 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 page 2.

Member information

Member name (print):

Member date of birth:

/ /

Member ID number:

I GIVE HEALTH NET 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 to help me with my benefits and services, or**
☐ **to permit Health Net to use or share my health information for** _____ .

Person or group to receive information (add additional persons or groups on page 2)

Name (person or group):

Address:

City:

State:

ZIP:

Phone:

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I authorize Health Net 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):**

 _____); **OR**
☐ **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, this authorization will expire in one year.

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).

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:

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Name (individual or entity):

Address:

City:

State:

ZIP:

Phone:

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Name (individual or entity):

Address:

City:

State:

ZIP:

Phone:

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Mail completed form to:

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

Phone: 1-800-522-0088, Fax: 818-676-8314

Revocation of Authorization to Use and/or Disclose Health Information

I want to cancel, or revoke, the permission I gave to Health Net 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 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.

Health Net Privacy Office

PO Box 9103, Van Nuys, CA 91409

Phone: 1-800-522-0088, Fax: 818-676-8314

English

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or call **1-800-522-0088** (TTY: 711).

Arabic

خدمات اللغة مجانية. يمكنك الحصول على مترجم فوري. ويمكنك الحصول على وثائق مقروءة لك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة الهوية، أو اتصل على مركز الاتصال التجاري (1-800-522-0088 (TTY: 711)

Armenian

Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեզ համար: Օգնության համար զանգահարեք մեզ ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք **1-800-522-0088** (TTY: 711).

Chinese

免費語言服務。您可使用口譯員。您可請人使用您的語言將文件內容唸給您聽，並請我們將有您語言版本的部分文件寄給您。如需協助，請致電您會員卡上所列的電話號碼與我們聯絡，或致電 **1-800-522-0088** (TTY: 711)。

Hindi

बनिा लागत की भाषा सेवाएँ। आप एक दुभाषयिा प्राप्त कर सकते हैं। आपको दस्तावेज पढ़ कर सुनाए जा सकते हैं। मदद के लिए, आपके आईडी कार्ड पर दिए गए सूचीबद्ध नंबर पर हमें कॉल करें, या **1-800-522-0088** (TTY: 711)।

Hmong

Kev Pab Txhais Lus Dawb. Koj xav tau neeg txhais lus los tau. Koj xav tau neeg nyeem cov ntaub ntawv kom yog koj hom lus los tau. Xav tau kev pab, hu peb tau rau tus xov tooj ntawm koj daim npav los yog hu **1-800-522-0088** (TTY: 711).

Japanese

無料の言語サービス。通訳をご利用いただけます。文書をお読みします。援助が必要な場合は、IDカードに記載されている番号までお電話いただくか、**1-800-522-0088**、(TTY: 711)。

Khmer

សេវាកម្មដោយឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ អ្នកអាចស្តាប់គេអានឯកសារឱ្យអ្នក។ សម្រាប់ជំនួយ សូមទាក់ទងយើងខ្ញុំតាមរយៈលេខទូរសព្ទដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក ឬ ទាក់ទងទៅមជ្ឈមណ្ឌលទំនាក់ទំនងពាណិជ្ជកម្មនៃក្រុមហ៊ុន **1-800-522-0088** (TTY: 711)។

Korean

무료 언어 서비스. 통역 서비스를 받을 수 있습니다. 귀하가 구사하는 언어로 문서의 낭독 서비스를 받으실 수 있습니다. 도움이 필요하시면 보험 ID 카드에 수록된 번호로 전화하십시오 **1-800-522-0088** (TTY: 711).

Navajo

Saad Bee Áká E'eyeed T'áá Jíík'e. Ata' halne'ígíí hóló. T'áá hó hazaad k'éhjí naaltsoos hach'í' wóltah. Shíká a'doowoł nínízingo naaltsoos bee néího'dółzinígíí bikáa'gi béesh bee hane'í bikáa' áajj' hodiílnih éí doodaii' **1-800-522-0088** (TTY: 711).

Persian (Farsi)

خدمات زبان به طور رایگان. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید که اسناد برای شما قرائت شوند. برای دریافت راهنمایی، با ما به شماره ای که روی کارت شناسایی شما درج شده تماس بگیرید یا با مرکز تماس بازرگانی **1-800-522-0088** (TTY: 711).

Panjabi (Punjabi)

ਬਨਿੰ ਕਸਿ ਲਾਗਤ ਤੇ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਕਰਿਪਾ ਕਰਕੇ 1-800-522-0088 (TTY: 711).

Russian

Бесплатная помощь переводчиков. Вы можете получить помощь устного переводчика. Вам могут прочитать документы. За помощью обращайтесь к нам по телефону, приведенному на вашей идентификационной карточке участника плана. Кроме того, вы можете позвонить в 1-800-522-0088 (TTY: 711).

Spanish

Servicios de idiomas sin costo. Puede solicitar un intérprete. Puede obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o comuníquese con el 1-800-522-0088 (TTY: 711).

Tagalog

Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng isang interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo. Para sa tulong, tawagan kami sa nakalistang numero sa inyong ID card o tawagan ang 1-800-522-0088 (TTY: 711).

Thai

ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังได้ สำหรับความช่วยเหลือ โทรหาเราตามหมายเลขที่ให้ไว้บนบัตรประจำตัวของคุณ หรือ โทรหาศูนย์ติดต่อเชิงพาณิชย์ของ 1-800-522-0088 (TTY: 711)

Vietnamese

Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu cầu được đọc cho nghe tài liệu. Để nhận trợ giúp, hãy gọi cho chúng tôi theo số được liệt kê trên thẻ ID của quý vị hoặc gọi 1-800-522-0088 (TTY: 711).