Authorization *for Disclosure of* Protected Health *Information*

For use in California, Arizona, Oregon and Washington

Completion of this document authorizes the disclosure of your protected health information (PHI) as set forth below. This authorization is required for the use or disclosure of your PHI beyond uses and disclosures for payment, treatment or health care operations to comply with the terms of federal HIPAA regulation 45 C.F.R. 164.508. A copy of this form is as valid as the original.

You hereby authorize Health Net to furnish to the person or entity identified below the health information described below.

Verification of individual whose information will be released – please print

Member name: ______________________________ Member date of birth: __________

Health Net identification #: ____________________ Member phone number: ______________

Member Address: ____

City: ___________________________________ State: _________ Zip: _________

Description of information to be released – please print

This authorization is limited to the following health information for (please specify date range): ______________

Check applicable box(es):

☐ Application, enrollment, eligibility information ☐ Account information

☐ Claims/Explanation of benefit information ☐ Pharmacy information ☐ Prior authorization

☐ Medical records ☐ Premium billing/Payment information

☐ I authorize Health Net to release information that may include a record of (select all that apply):
☐ Drug treatment ☐ Alcohol treatment

☐ I authorize Health Net to release confidential HIV/AIDS-related information, including AIDS-related complex (ARC) or confidential communicable disease-related information for the purpose of: __________________

☐ Other information (please describe): ____

Person or entity to receive information

Name: ___________________________ Company (if applicable): __________________

Address: ____

City: ___________________________________ State: _________ ZIP: _________

Phone number: ____

(continued)

Health Net of Arizona, Inc., Health Net of California, Inc., Health Net Health Plan of Oregon, Inc., Health Net Life Insurance Company, have a contract with Medicare to offer HMO, PPO, HMO SNP plans. Enrollment in a Health Net Medicare Advantage plan depends on contract renewal.

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Expiration of authorization

This authorization will expire ________________ *(mm/dd/yy)*. **Note:** The length of time this authorization is valid may not exceed one year in California, 180 days in Washington and two years in Oregon.

Important information

- Information disclosed based on this authorization could be re-disclosed by the recipient and may no longer be protected by federal privacy regulations.
- You may revoke this authorization at any time in writing by sending it to the Health Net Privacy Office, Attention Director, Information Privacy, PO Box 9103, Van Nuys, California 91409 as set forth in Health Net's Notice of Privacy. Your 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.
- Neither payment, enrollment nor eligibility for benefits will be conditioned on your providing or refusing to provide this authorization. This restriction does not apply if Health Net is seeking to obtain information in connection with your eligibility or enrollment in Health Net when you are not already a member or to obtain information required for payment of a specific claim for benefits.
- You have a right to receive a copy of this authorization.

To return your completed form

Members:
Mail to: Health Net Privacy Office
PO Box 9103
Van Nuys, California 91409

Brokers:
Fax to the appropriate Broker Hub:
AZ: 877-693-2202
CA: 800-845-7429
OR/WA: 866-455-3869

By signing this authorization, you agree that you have read and understand the above information, and that your signature authorizes the disclosure of the information described above.

Signature of member or authorized representative:

____ Date: ______________________

Relationship – description of authority if the person signing is other than the member whose information is disclosed:

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If this authorization is signed by a authorized representative of the member, we will require verification of the individual's authority to act as authorized representative before any PHI is disclosed pursuant to this authorization.