Authorization for the Use and/or Disclosure of Protected Health Information ("PHI").

The authorization for use and 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.

Please print clearly ***Required fields**

Member name* ____
Last First Initial

Address* ____
Street City State Zip

Phone* ____________________

Date of birth* ____________ Member ID#* ____________ Health plan* ____________

Mailing address: (Specify where you would like your PHI mailed to if different than above)

Name ____
Last First Initial

Address ____
Street City State Zip

1. I authorize the use or disclosure of the above named individual's Protected Health Information as described below.
"All medical issues pertaining to claims, authorizations, bills and treatment."
2. The following individual or organization is authorized to make the disclosure:
North American Medical Management California, Inc./PrimeCare Medical Network, Inc., or any affiliated IPA thereto.
3. **This information may be disclosed to and used by the following individual or organization:**

Name* ____
PHI representative

Turn over ▶

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***Required fields**

4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: __________. If I fail to specify an expiration date, event or condition, this authorization will not expire.
5. I understand that authorizing the disclosure of this PHI is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

______________________________ ______________________________

Signature of member or †legal representative* Date*

______________________________ ______________________________

If not member, state relationship Date

______________________________ ______________________________

Signature of witness Date

†By signing this form, I represent that I am the legal representative of the member identified above and will provide written proof (e.g. power of attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the member's behalf with respect to this authorization form.

Legal representative address: (If applicable)

Name ____
Last First Initial

Address ____
Street City State Zip