Western Health Advantage

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

If you have any questions, please call Member Services at 916.563.2250, 888.563.2250 toll-free or 888.877.5378 TDD/TTY.

A. Use this form to authorize Western Health Advantage ("WHA") to use or to disclose your health information to another person or organization.

1. Person (the "Member") whose information is to be disclosed

Member name and address:_____

Member ID number: _____ Date of birth: _____

2. Person (the "Recipient") authorized to receive the Member's information

Recipient's name: _____

Recipient's address: _____

Recipient's relationship to the Member: _____

3. Information to be disclosed to the Recipient

check one: ❍ Any or all information that WHA maintains. This may include information relating to the Member's medical care, diagnosis, providers, insurance or benefit claims/payments, and/or financial/billing information. This does not include Sensitive Information unless specifically approved below.

OR Only the following information, or types of information, WHA maintains (check all that apply):

❍ Claims status ❍ Authorization status ❍ Referral status ❍ Other _____

4. Is the Recipient authorized to receive Sensitive Information as described below?

check one: ❍ NO – PROCEED TO SECTION 5

OR ❍ YES – SELECT ONE (a or b) OF THE FOLLOWING

I specifically authorize the Recipient to receive:

a. ❍ Psychotherapy notes: If you check this box, you may not check any of the other boxes in section b. below. An authorization for the release of psychotherapy notes may not be combined with an authorization for disclosure of any other type of information. PROCEED TO SECTION 5.

OR b. ❍ Complete this section ONLY IF you did not check box 4(a) above and you wish to authorize disclosure of any of the following types of Sensitive Information* (check all that apply):

❍ All sensitive information OR ❍ Abortion ❍ Alcohol/substance abuse** ❍ Genetic information
❍ HIV/AIDS ❍ Mental health ❍ Pregnancy
❍ Sexual, physical, or mental abuse ❍ Sexually transmitted illness

*Note to parents/legal guardians of minors 12 years of age or older: You may be unable to obtain or authorize the use or disclosure of certain types of Sensitive Information about the minor without the minor's own written authorization. This may include the types of Sensitive Information listed above as well as information regarding infectious diseases, rape/sexual assault, and certain outpatient mental health counseling/treatment. If the minor is 17 years of age or older, disclosure of information relating to domestic violence and blood donations also requires the minor's authorization.

**For Recipient of Substance Abuse Information: This information has been disclosed to you from records protected by the Federal Confidentiality of Alcohol or Drug Abuse Records rules (42 CFP part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for release of medical information or other information is not sufficient for this purpose.

5. Reason for this authorization

check one: ❍ The information is about me and is to be used or disclosed at my request.

❍ Other (please specify): _____

B. Expiration and revocation

This authorization will remain in effect for one year from the date of your signature below UNLESS a different date is specified here: Month_____ Day _____Year _____

You have the right to revoke this authorization at any time by notifying WHA in writing. Revoking this authorization will not affect information we use or disclose before we receive your revocation request. If this authorization is given by a parent or legal guardian on behalf of a minor, it will expire on the minor's eighteenth birthday.

C. Signature

I have read this form, and I understand and agree to its terms. I direct WHA to use or to disclose the information to the Recipient as directed above. I understand that once my information is disclosed, it could be re-disclosed by the Recipient and may no longer be protected by privacy laws, including the federal Health Insurance Portability and Accountability Act of 1996. I also understand that signing this form is of my own free will.

I understand that WHA may not condition payment, enrollment in a health plan or eligibility for benefits on whether I sign this authorization. I am entitled to a copy of this form.

Signature _____ Date _____

Print name _____

D. Personal or legal representatives or guardians

If this form is signed by someone other than the Member or the parent of a minor, such as a personal/legal representative, guardian or executor, you must also submit legal documentation showing your authority to act on behalf of the Member (or the Member's estate) to authorize the use or disclosure of the Member's health information. Such documentation may include, for example: 1) Durable Health Care Power of Attorney; 2) current, valid documentation of court-ordered guardianship; or 3) other valid legal documentation showing your authority to act on behalf of the Member (or the Member's estate).

Please also complete the following:

Representative's name (print): _____

Relationship to Member: _____

Type of documentation submitted: _____

Keep a copy of this Authorization for your records.

Mail completed form to: Western Health Advantage, Attn: Member Services
2349 Gateway Oaks, Suite 100, Sacramento, CA 95833

Secure fax: 916.563.2207

Secure email via: mywha.org/securemessage – select A Message For: Member Services

Online form at: mywha.org/privacy

Questions? Call: 916.563.2250 | 888.563.2250 toll-free | 888.877.5378 TDD/TTY

FOR INTERNAL USE ONLY Initials: _____ Date Entered: _____