Authorization For Use or Disclosure of Health Information

Mail to: Western Health Advantage, Attn: Member Services
2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833
Fax to: 916.568.0126
Email to: memberservices@westernhealth.com
Include in Subject Line: Authorization for Use or Disclosure
Questions? 916.563.2250, 888.563.2250 toll-free or 888.877.5378 for 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. Member whose information is to be disclosed

Name: _____

Address: _____

Member ID Number: _____ Date of Birth: _____

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

Recipient's Name: _____ Relationship to Member: _____

Recipient's Address: _____

3. Information to be disclosed to the Recipient (check only one of the three options)

❑ **All information** that WHA maintains, excluding Sensitive Information unless specifically authorized in section 4.

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

- ❑ Medical Information (diagnosis, treatment, medication, including authorizations and referral status)
- ❑ Health Plan Coverage and Eligibility
- ❑ Financial/Billing Information (e.g. Premium payments), excluding claims information
- ❑ Claims Status/Payment Information
- ❑ Other _____

OR ❑ Psychotherapy notes

If you check this box, you may not check any of the other boxes in this section or in section 4. An authorization for the release of psychotherapy notes may not be combined with an authorization for disclosure of any other type of information; a separate form must be used.

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

❑ NO ❑ YES If Yes, I specifically authorize WHA to release to Recipient:

❑ **All sensitive information** OR ❑ **Only the following information:** (check all that apply)

- ❑ Alcohol/substance abuse ❑ Mental health ❑ Genetic information
- ❑ Sexually transmitted illness (including HIV/AIDS)
- ❑ Sexual, physical, or mental abuse
- ❑ Abortion/reproductive health (including pregnancy, contraception)

5. Reason for this authorization (check only one)

❑ Personal Use ❑ Legal ❑ Other (please specify): _____

6. Authorization to Act on Member's Behalf

I authorize the Recipient to perform the following acts:

- ❑ Enroll me/disenroll in/from Plan
- ❑ Choose/change my PCP
- ❑ Request new ID Card
- ❑ Change/correct missing/erroneous demographic information
- ❑ All of the above

B. Expiration

This authorization will remain in effect:

❑ for one (1) year from the date of your signature below, OR

❑ until Month _____ Day _____ Year_____ (this period cannot be longer than 3 years from the date of signature below)

C. Notice to Member

- You can revoke this authorization at any time by notifying WHA in writing. Revoking this authorization will not affect information WHA used or disclosed before receipt of the revocation request.
- WHA may not condition treatment, payment, enrollment in a health plan or eligibility for benefits on whether you or your representative sign this authorization.
- If this authorization is on behalf of a minor,
  - o federal and state laws may prohibit WHA from acting on your request about Sensitive Information without written authorization from the minor 12 years of age or older;
  - o it will expire when the minor turns 18 or is legally emancipated, or may be revoked by the legally capacitated minor.
- State law prohibits the re-disclosure of medical information by a Recipient without a separate authorization. If the requested information is re-disclosed, it may no longer be protected by federal privacy laws.
- If the requested information is Substance Abuse Information, this was disclosed from records protected by federal confidentiality rules. 42 CFR part 2 prohibits unauthorized disclosure of these records.
- You are entitled to a copy of this form.
- If you send a completed form by email to WHA, you acknowledge that it is not best practice to send protected health information through email that is not secure.

D. 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 am signing this form of my own free will.

Signature_____ Date_____

Print Name_____

Relationship to Member (if applicable):_____

A copy of a photo ID of the person signing the form and of the Recipient, unless one is already on file with WHA, must be attached to this form.

Personal or legal representatives or guardians: If this form is signed by someone other than the Member or the parent of a minor, this authorization must be accompanied by documentary proof of the authority to act on behalf of the Member (or the Member's estate).

Keep a copy of this Authorization for your records.

WHA Internal Use Only

Date Request Received _____ ❑ Identification Verified (documents checked)

Signature of Manager or Supervisor _____

Printed Name _____