

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

Fax to: 916.568.0126

Email to: memberservices@westernhealth.com

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

FOR INTERNAL USE ONLY Initials _____ Date Entered _____

Western Health Advantage complies with applicable Federal and California civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, as applicable. Western Health Advantage does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Western Health Advantage:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the Member Services Manager at 888.563.2250 and find more information online at <https://www.westernhealth.com/legal/non-discrimination-notice/>.

If you believe that Western Health Advantage has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance by telephone, mail, fax, email, or online with: Member Services Manager, 2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833, 888.563.2250 or 916.563.2250, 888.877.5378 (TTY), 916.568.0126 (fax), memberservices@westernhealth.com, <https://www.westernhealth.com/legal/grievance-form/>. If you need help filing a grievance, the Member Services Manager is available to help you. For more information about the Western Health Advantage grievance process and your grievance rights with the California Department of Managed Health Care, please visit our website at <https://www.westernhealth.com/legal/grievance-form/>.

If there is a concern of discrimination based on race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

Website: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>; Mail: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; Phone: 800.368.1019 or 800.537.7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ENGLISH

If you, or someone you're helping, have questions about Western Health Advantage, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 888.563.2250 or TTY 888.877.5378.

SPANISH

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Western Health Advantage, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 888.563.2250, o al TTY 888.877.5378 si tiene dificultades auditivas.

CHINESE

如果您，或是您正在協助的對象，有關於Western Health Advantage方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話888.563.2250或聽障人士專線(TTY) 888.877.5378。

VIETNAMESE

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Western Health Advantage, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số 888.563.2250, hoặc gọi đường dây TTY dành cho người khiếm thính tại số 888.877.5378.

TAGALOG

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Western Health Advantage, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 888.563.2250 o TTY para sa may kapansanan sa pandinig sa 888.877.5378.

KOREAN

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Western Health Advantage에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 888.563.2250이나 청각 장애인용 TTY 888.877.5378로 연락하십시오.

ARMENIAN

Եթե Դուք կամ Ձեր կողմից օգնություն ստացող անձը հարցեր ունի Western Health Advantage-ի մասին, Դուք իրավունք ունեք անվճար օգնություն և տեղեկություններ ստանալու Ձեր նախընտրած լեզվով: Թարգմանչի հետ խոսելու համար զանգահարե՛ք 888.563.2250 համարով կամ TTY 888.877.5378՝ լսողության հետ խնդիրներ ունեցողների համար:

PERSIAN-FARSI

اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Western Health Advantage (وسترن هلث ادونتیج) داشته باشید حق این را دارید که کمک و اطلاعات ب ژبا نخود را به طو رایگان دریافت نمایید. لطفا با شماره تلف 888.563.2250 تم اسگیرید. افراد ناشنو می تواند نذبه شمار 888.877.5378 پیام تایید یرسا لکنند

RUSSIAN

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Western Health Advantage, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 888.563.2250 или воспользуйтесь линией TTY для лиц с нарушениями слуха по номеру 888.877.5378.

JAPANESE

ご本人様、またはお客様の身の回りの方でも、Western Health Advantageについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、888.563.2250までお電話ください。聴覚障がい者用TTYをご利用の場合は、888.877.5378までお電話ください。

ARABIC

إن كان لديك أو لدى شخص تساعد أسئله بخصوص Western Health Advantage، فلديك الحق في الحصول على المساعدة والمعلوما ت الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل ب 888.563.2250، أو برقم الهاتف النصي (TTY) لضعاف السمع 888.877.5378.

PUNJABI

ਜੇਕਰ ਤੁਸੀਂ, ਜਾਂ ਜਿਸ ਕਿਸੇ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਦੇ Western Health Advantage ਬਾਰੇ ਸਵਾਲ ਹਨ ਤਾਂ, ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਹਾਸਲ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਆਰਾ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 888.563.2250 'ਤੇ ਜਾਂ ਪੂਰੀ ਤਰ੍ਹਾਂ ਸੁਣਨ ਵਿੱਚ ਅਸਮਰਥ ਟੀਟੀਵਾਈ ਲਈ 888.877.5378 'ਤੇ ਕਾਲ ਕਰੋ।

CAMBODIAN-MON-KHMER

ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលកំពុងជួយអ្នក មានសំណួរអំពី Western Health Advantage ទេ, អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មាន នៅក្នុងភាសារបស់អ្នក ដោយមិនអស់ប្រាក់។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែ សូមទូរស័ព្ទ 888.563.2250 ឬ TTY សម្រាប់អ្នកត្រចៀកធ្ងន់ តាមលេខ 888.877.5378។

HMONG

Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Western Health Advantage, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 888.563.2250 los sis TTY rau cov neeg uas tsis hnov lus zoo nyob ntawm 888.877.5378.

HINDI

यदि आप, या जिस किसी की आप मदद कर रहे हो, के Western Health Advantage के बारे में प्रश्न हैं तो, आपको अपनी भाषा में मदद तथा जानकारी प्राप्त करने का अधिकार है। दुआशिए के साथ बात करने के लिए, 888.563.2250 पर या पूरी तरह श्रवण में असमर्थ टीटीवाई के लिए 888.877.5378 पर कॉल करो।

THAI

หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Western Health Advantage คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย เพื่อพูดคุยกับล่าม โทร 888.563.2250 หรือใช้TTY สำหรับคนหูหนวกโดยโทร 888.877.5378