AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO FAMILY MEMBER OR FRIEND INVOLVED IN MEMBER CARE

Instructions

This "Authorization for Use or Disclosure of Protected Health Information to Family Members and Friends Involved in Member Care" form helps CalOptima protect your privacy. We are asking you to complete this form to let us know you want us to release your protected health information. Please read the information on this page and complete the form on the next page.

If you have questions or need help completing this form, call CalOptima's Customer Service Department at **1-714-246-8500** or toll-free at **1-800-587-8088**, Monday through Friday from 8 a.m. to 5:30 p.m. Members with hearing or speech impairments can call our TDD line at **1-800-735-2929**.We have staff who speak your language.

Member Rights

- I understand that I must receive a copy of this Authorization.
- I understand that I may ask to receive additional copies of this Authorization.
- I understand that I may refuse to sign this Authorization.
- I understand that I may cancel this Authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this Authorization.

Right to Cancel

I understand that I have the right to cancel this Authorization at any time. To cancel this Authorization, I understand that I must make my request in writing and clearly state that I am cancelling this specific Authorization. In addition, I must sign my request and then mail, deliver in person or fax my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868
Fax: 1-714-338-3104

I understand that canceling this Authorization will not affect the ability of CalOptima or any health care provider to use or disclose the protected health information to the extent that it has relied on this Authorization.

Restrictions

I understand that health information used or disclosed as a result of my signing this Authorization may not be further used or disclosed by the recipient unless another authorization is obtained from me or unless such use or disclosure is specifically permitted or required by law.

Please complete and return to CalOptima

Part A: Member Information

Last Name: ______________________________ First Name: ____________________________

CalOptima ID # (CIN): ____________________ Date of Birth:___________________________

Address: ____

City: ___________________________________ Zip: ___________________________________

Phone (Home): __________________________ Phone (Cell): ___________________________

Preferred Language: _____________________

Part B: Authorization

Please check the appropriate box below to authorize CalOptima to use or disclose your protected health information. CalOptima may use or disclosure**:**

☐ All of my protected health information, OR

☐ Limit the use or disclosure of information to the following:

____

____

Part C: Person(s) to Receive Information Listed in Part B

Please print the name of the person(s) authorized to obtain your protected health information. Person(s) listed below must be over 18 years of age.

____

Part D: Purpose of the Authorization

☐ To use or disclose the information, at my request, OR

☐ For the following specific purpose: ____

Part E: Expiration Date

This Authorization shall become effective immediately and will end on: ___________________________ or three years from the date of signature, whichever is earlier. Date or Event

Part F: Signature

Signature of Member: ____ Date: ____________________

Signature of Parent or Legal Guardian: _____________________________ Date: ____________________

Basis for legal authority to sign this Authorization by a Personal Representative

(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or administrator of a deceased member's estate), a Designated Consent from a Regional Center Director or designee (pursuant to Welfare and Institutions Code Section 4655), or other legal documentation showing the authority of the personal representative to act on the individual's behalf must be attached to this form.)

Name of Personal Representative: ____

Legal Relationship to Member: ____

Signature of Personal Representative: ____

Date: ____