

COMPLETING YOUR AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

The Authorization for Release of Health Information Form is required for release of Protected Health Information (PHI) in compliance with the Health Insurance Portability and Accountability Act of 1996.

The Individual is the person who is authorizing the release of his or her PHI. The Individual can be the DGA member who earned the health coverage or one of his or her dependents. The Participant is the DGA member who earned the health coverage. **The Plan is required to have a separate form for each Individual age 18 and over that is signed by that Individual. Forms submitted on behalf of an Individual age 18 and over that are not signed by that Individual are invalid.**

SECTION A

Give a description of the health and/or eligibility information that you are allowing the Health Plan to disclose on your behalf. You may be as general or as specific as you choose.

Example of a general description: *All health claims and all health eligibility information*

Example of a specific description: *Information regarding my surgery on December 3, 2007*

SECTION B

Give the full name of the person or organization to which you are allowing the Health Plan to release your health information. Please do not fill in your relationship to the person or organization. Instead, please specifically name the person or organization.

Examples: *John Smith*
California Management, Inc.

SECTION C

State the purpose for which the Health Plan is allowed to release health information to the person or organization named in Section B.

Examples: *To assist with my healthcare*
At the request of the individual

SECTION D

Specify when the authorization will expire. Please specify an expiration date or event. Once your authorization expires, the Health Plan will require a new Authorization for Release of Health Information Form before releasing any of your Protected Health Information.

Example of an expiration date: *12/31/06*

Example of expiration upon occurrence of an event: *Termination of participation in Plan*

It is very important that you complete Sections A, B, C and D of the Authorization for Release of Health Information Form. The form will be invalid if Sections A, B, or C are left blank or if the form is not signed. If you do not complete Section D, then your authorization will remain in effect for 1 year, or until it is revoked by you in writing, whichever is earlier.

Please call the Health Plan Office at one of the numbers below, extension 401, if you need any help completing the Authorization for Release of Health Information Form.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Once completed, you can fax this form to (323) 866-2326. No cover sheet is necessary.

I hereby authorize the DGA-Producer Health Plan (the "Plan") to disclose certain individually identifiable health information described in Section A to the persons in Section B for the purposes described in Section C.

Individual's Name: _____

The Individual listed above is the person who is authorizing the release of his or her Protected Health Information. The Individual can be the DGA member who earned the Health Plan coverage or one of his or her dependents.

Participant's Name: _____

The Participant listed above is the DGA member who earned the Health Plan coverage.

Participant's SSN: _____

SECTION A

Give a specific description of the information to be used or disclosed (include dates, if applicable):

SECTION B

Persons/organizations authorized to receive the information:

SECTION C

Specific purpose of the disclosure (If you, the individual, are requesting the disclosure, and you don't want to describe your reasons, you may write *At the request of the individual*):

This authorization is not valid if you do not fully complete Sections A, B and C.

SECTION D

This authorization will expire on:

_____ or _____
Date Event

If you do not select an expiration date or event, your authorization will remain in effect for one (1) year or until revoked by you in writing, whichever is earlier.

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION (CONTINUED)

IMPORTANT INFORMATION ABOUT YOUR RIGHTS

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the Plan in writing, but the revocation will not have any effect on any actions the Plan took before it received the revocation.
- I am entitled to a copy of this authorization.
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity without my authorization.
- I understand that I am not required to sign this form to receive my health care benefits, although I must complete all applicable forms for benefits.
- I understand that I may decline to sign this authorization. However, it will be invalid if not signed.

X

Date: _____

Signature of Individual or Individual's Personal Representative
(Form must be completed before signing)

Below, if applicable, print the name of the individual's personal representative (person who has the legal status as personal representative of the individual, such as power of attorney for health matters or legal guardian). Please attach a copy of legal status.

Below, print the relationship of the representative to the individual, including authority for status as representative:

If you have any questions regarding this form, please contact the Health Plan Department at one of the numbers below, extension 401.