DGA-PRODUCER PENSION & HEALTH

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. A custodial parent submitting the form on behalf of his or her covered dependent under the age of 18 will need to list on page 2 the parent's name as the person submitting the form and list on page 1 the name of dependent as the Individual whose PHI will be released. **The Plan is required to have a separate form for each Individual age 18 and over that is signed by that Individual or that Individual's personal representative subject to the requirements outlined below. Forms submitted on behalf of an Individual age 18 and over that are not signed by that Individual (or his or her personal representative) 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

COMPLETING YOUR AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION (CONTINUED)

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 contact the Health Plan Office if you need assistance in completing the Authorization for Release of Health Information Form. Your questions or the completed form can be submitted by mail, fax, email or online as follows:

Mail: DGA–Producer Pension and Health Plans
5055 Wilshire Blvd, Suite 600
Los Angeles, CA 90036
Fax: (323) 782-9287
Phone: (323) 866-2200, ext. 401
Email: hpclaims@dgaplans.org
Online: via the myPHP online benefits portal. Registration is required.

DGA-PRODUCER PENSION & HEALTH

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Once completed, you can return this form by fax to (323) 782-9287, email to hpclaims@dgaplans.org or online via the myPHP online benefits portal. (Registration is required.) 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.

Individual's Plan ID# (or last 4 of SSN and Date of Birth): _____

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.

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 Custodial Parent
(Form must be completed before signing)

Print your name below if you are submitting this authorization on behalf of the Individual (i.e., as a custodial parent of an Individual who is under the age of 18 or as a person who otherwise has the legal status as personal representative of the Individual (such as power of attorney for health matters or legal guardian). If submitting this authorization other than as a custodial parent of the Individual, please attach a copy of legal status.

_____

_____

Below, print the relationship of the representative to the Individual, including authority for status as representative (e.g., custodial parent, other legal guardian or power of attorney for health matters):

_____

_____

If you have any questions regarding this form, please contact the Health Plan Department using the information below.

DGA–Producer Pension and Health Plans
5055 Wilshire Blvd, Suite 600
Los Angeles, CA 90036
Fax: (323) 782-9287
Phone: (323) 866-2200, ext. 401
hpclaims@dgaplans.org