Authorization to Use and Disclose Health Information

NOTICE TO MEMBER:

- Completing this form will allow California Health & Wellness to (i) use your health information for a particular purpose, and/or (ii) share your health information with the individual or entity that you identify on this form.
- You do not have to sign this form or give permission to use or share your health information. Your services and benefits with California Health & Wellness will not change if you do not sign this form.
- Right to cancel (revoke): This authorization/consent form is subject to revocation at any time except to the extent that California Health & Wellness or other lawful holder of your health information that is permitted to share it has already acted on your consent. If you want to cancel this Authorization Form, fill out the Revocation Form on page 3 and mail it to the address at the bottom of the page.
- California Health & Wellness cannot promise that the person or group you allow us to share your health information with will not share it with someone else.
- Keep a copy of all forms that you send to us. We can send you copies if you need them.
- Fill in all the information on this form. When you have finished, mail it to the address at the bottom of page 2.

Member information

Member name (print):	
Member date of birth: / /	Member ID number:

I GIVE CALIFORNIA HEALTH & WELLNESS CONSENT TO USE MY HEALTH INFORMATION FOR THE PURPOSE NAMED AND TO SHARE MY HEALTH INFORMATION WITH THE PERSON OR GROUP NAMED BELOW. THE PURPOSE OF THE APPROVAL IS TO:

☐ **Allow California Health & Wellness to help me with my benefits and services.**
☐ **Permit California Health & Wellness to use or share my health information for _____.**

Person or group to receive information (add additional persons or groups on page 2)

Name (person or group):			
Address:			
City:	State:	ZIP:	Phone:

I give my consent for California Health & Wellness to use or share the following health information:

☐ All of my health information (**THIS INCLUDES:** genetic information, services or test results. It also includes HIV/AIDS data and records and mental health data and records [but not Psychotherapy notes]. Health information also includes prescription drug/medication data and records, and drug and alcohol data and records): **OR**

☐ **All of my health information EXCEPT (check all boxes that apply):**

- ☐ Genetic information, services or tests
- ☐ HIV/AIDS data and records
- ☐ Drug and alcohol data and records
- ☐ Mental health data and records (but not psychotherapy notes)
- ☐ Prescription drug/medication data and records
- ☐ Other: _____

Expiration of authorization

This authorization will expire on / / (mm/dd/yy). It will be valid for a one-year maximum. If no date is given, it will expire one year from the date below.

Member signature (member or legal representative sign here):	Date: / /

If you are signing for the member, describe how you know the member below. If you are the member's Personal Representative, describe this below. And, send us copies of those forms (e.g. power of attorney or order of guardianship).

_____

Other person(s) or entity(ies) to receive information

NOTE: If you are consenting to disclose any substance use disorder records to a recipient that is neither a third party payor nor a health care provider, facility, or program where you receive services from a treating provider, such as a health insurance exchange or a research institution (hereafter, "recipient entity"), you must specify the name of an individual with whom or the entity at which you receive services from a treating provider at that recipient entity, or simply state that your substance use disorder records may be disclosed to your current and future treating providers at that recipient entity.

Name (individual or entity):			
Address:			
City:	State:	ZIP:	Phone:

Name (individual or entity):			
Address:			
City:	State:	ZIP:	Phone:

Name (individual or entity):			
Address:			
City:	State:	ZIP:	Phone:

Mail finished form to:
California Health and Wellness
Eligibility Department
PO Box 10420, Van Nuys, CA 91499-6208
Phone: 800-275-4737
Fax: 844-222-3180

Revocation of Authorization to Use and/or Disclose Health Information

I want to cancel, or revoke, the consent I gave to California Health & Wellness to use my health information for a certain purpose and, consent I gave to share my health information with a person or group.

Person or group that received the information			
Name (person or group):			
Address:			
City:	State:	ZIP:	Phone:
Authorization signed date (if known): / /			

Member information	
Member name (print):	
Member date of birth: / /	Member ID #:

I understand that my health information may have been used by now, or shared because of the consent I gave before (including, as needed, my substance use disorder records.) I also know that this cancellation only applies to the consent I gave to use my health information for a certain purpose or, consent to share my health information with a person or group. **It does not cancel any other approval forms I signed** for health information to be:

1. Used for another purpose.
2. Shared with another person or group.

Member signature (member or legal representative sign here):	Date:

If you are signing for the member, describe how you know the member below. If you are the member's personal representative, describe this below. And, send us copies of those forms (e.g. power of attorney or order of guardianship).

_____

California Health & Wellness will stop using or sharing your health information when we receive and process this form. Use the mailing address below. You can also call for help at the number below.

California Health & Wellness
Eligibility Department
PO Box 10420, Van Nuys, CA 91499-6208
Phone: 800-275-4737, Fax: 844-222-3180

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