Authorization for Disclosure of Protected Health Information

Completion of this document authorizes CCA Health California ("CCA Health"), to use or disclose myprotected health information (PHI) as described below:

Section I. Individual whose information will be disclosed			
Name:	Member ID number:		Date of birth:
Address:			
City:	State:	ZIP:	Phone number:

Section II. Description of information to be disclosed

I authorize CCA Health to disclose the following types of health information.

A. General description of health information (please select all that apply):

☐ Application, enrollment, membership, and eligibility records and information
☐ Claims/Explanation of Benefits/Evidence of Coverage records and information
☐ Pharmacy records and information
☐ Premium/payment/billing information and records
☐ Other information (please describe):_____

B. Additional description of sensitive information categories (please select all that apply):

You must complete this section to authorize the release of information and records regarding the following sensitive information categories:

☐ Drug or alcohol abuse diagnosis, treatment, prognosis, or referral
☐ HIV/AIDS (including AIDS-related complex (ARC)) or sexually transmitted diseases (STDs)
☐ Genetic testing
☐ Mental or behavioral health services

Section III. Purpose

I authorize CCA Health to disclose the information identified above for the following purpose(s):

☐ At my request
☐ Other (please specify):_____

Section IV. Expiration of authorization

This authorization will expire on_____(mm/dd/yy).
If no date is provided, this authorization will expire in one year.

Section V. Person or entity to receive information

I authorize disclosure of my health information as indicated above to the following:

Name:		Company (if applicable):	
City:	State:	ZIP:	Phone number:
Name:		Company (if applicable):	
City:	State:	ZIP:	Phone number:

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Section VI. Important information

- Information disclosed based on this authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations, including HIPAA.
- I may revoke this authorization in writing by sending a written notice to the CCA Privacy Officer at 18000 Studebaker Rd., Suite 150, Cerritos, CA 90703. My revocation will be effective upon receipt but will not be effective to the extent that CCA or others have acted in reliance upon this authorization.
- Treatment, payment, enrollment, or eligibility for benefits are not conditioned on my providing or refusing to provide this authorization, unless I have not yet enrolled with CCA Health and CCA Health is seeking to obtain information in connection with determining my eligibility for benefits or enrollment, or unless CCA Health is requesting the information for underwriting or risk rating purposes.
- I have a right to receive a copy of this authorization. A copy is as valid as the original.

Section VII. Acknowledgment

By signing this authorization, I acknowledge that I have read and understand the above information, and that my signature authorizes the disclosure of the information described above.

(Signature of member or personal representative) Date

(Printed name of member, or personal representative)

(Relationship – description of authority to act on behalf of the member, if applicable)

If this authorization is signed by anyone other than the member, CCA Health may require verification of the individual'sauthority to act on behalf of the member before any PHI is disclosed pursuant to this authorization.