AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

Health Plan of San Joaquin | Mountain Valley Health Plan

The Health Insurance Portability and Accountability Act requires that you give permission to Health Plan of San Joaquin/Mountain Valley Health Plan ("Health Plan") to use or share health information in certain cases. California Civil Code §56.10 will not allow the person or company who receives your information to share it with others unless you give them permission, or they are allowed to by law.

Please answer all questions on the following pages. Health Plan may already have filled in some answers. All pages of the form must be completed. After you fill out the form, mail or take it to Health Plan at one of the following locations:

7751 South Manthey Road **French Camp, CA 95231-9802**	**1025 J Street** **Modesto, CA 95354**

You may also fax the form to: **1-209-461-2550**

1. Give a specific description of the health information to be used or shared. (dates of coverage, dates of treatment, type of injury or illness, and names of doctors, hospitals or other providers will help us to respond to your request faster):

2. The health information will be used or shared only for the following reason(s):

3. Please select the person or company who is requesting that the health information be shared:

- ☐ Member
- ☐ Personal representative of the member. (Examples: parent or legal guardian.)
- ☐ Health Plan (Please be advised that Health Plan does not receive payment for sharing information.)

4. List the person or company who has permission to receive the health information:

- ☐ Grandparent(s). Name(s):_____
- ☐ Non-custodial parent or stepparent(s). Name(s): _____
- ☐ Other relative, companion or friend of the member:
  Name: _____ Relationship:_____
- ☐ Member's Attorney. Name:_____
- ☐ Other. Name:_____

_____ _____

Print Name of Member | Health Plan ID Number

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**5. This permission expires on (give date or event) ****this document is not valid if this question is not answered:*
☐ Date (MM/DD/YYYY):_____ ☐ Event:_____

You have the right to refuse to sign this form. If you refuse to sign this form, your information will not be used or shared as indicated on this form. Your refusal to sign this form will not affect your treatment or eligibility for benefits, or Health Plan's payment of services.

If you do sign the form, you have the right to change your mind at any time. You will need to do this by writing to Health Plan. Your request will be effective on the date we receive it, but we will not be able to stop any action that may have already taken place.

…… ……

Print Name of Member **Health Plan ID Number**

……

Telephone Number

…… ……

Signature of Member **Date**

…… ……

Signature of Personal Representative **Date**

Note, if you are acting as the Personal Representative of a member, please tell us your relationship to the member:

……

Relationship to the Member

You may be required to show us proof of your legal permission to act for the member.

If you are filling out this form because you want Health Plan to give information to another person or company, you should make a copy of it for your records. If Health Plan is asking your permission to use or share information for its own reasons, a copy of this authorization will be sent to you after you sign it. Should you have any questions about this form, please contact our Customer Service department at **1-209-942-6320**.

Print Name of Member Health Plan ID Number