AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Important Information

To allow Partnership HealthPlan of California, or another entity, to release your medical information, you must first give your authorization. Please complete this form and send it to:

Partnership HealthPlan of California
Attn: Member Services – Northern Region
3688 Avtech Pkwy
Redding, CA 96002
(530) 223-2508

OR

Partnership HealthPlan of California
Attn: Member Services – Southern Region
4665 Business Center Drive
Fairfield, CA 94534
Fax: (707) 420-7580

Member Information

First Name:	Last Name:
Address:	
Phone Number: ( )	Date of Birth:
Member ID/CIN:	

I request (ask) and authorize _____ to release the medical information checked below of the member named above to the person or entity named below:

Name:				
Address:				
Phone Number: Fax Number:	( ) ( )			
For The Following Specific Use(s) / Purpose(s):	❑ Personal Use	❑ Legal	❑ Workers' Comp	❑ Medical Treatment
	❑ Eligibility	❑ Disability	❑ Other:	
Specific Date(s) of Service:	FROM: _____	TO: _____		

This Authorization is limited to the medical information checked below:

(PLEASE NOTE: The sensitive health information below requires separate signature.)

❑ Copies of records or health information ***except*** sensitive health information.	❑ Copies of records or health information ***including*** the sensitive information indicated below.
❑ Mental/Behavioral Health Treatment _____ Signature of Member or Personal Representative	❑ Sexually Transmitted Disease Treatment _____ Signature of Member or Personal Representative
❑ Substance Use Disorder Treatment _____ Signature of Member or Personal Representative	Description of Substance Use Disorder information: _____ _____

❑ Medical information relating to the following specific medical provider, treatment, or condition: _____

Authorization Expiration

This Authorization will expire (end) in exactly one year unless you choose a different date below.
This Authorization will expire on this date or event:_____

Signature of Member

I understand that Partnership HealthPlan of California and other organizations and individuals such as doctors, hospitals and health plans are required by law to keep my health information confidential (private). Under California law, the recipient of my medical information is prohibited from re-disclosing (sharing) the information, except with a written authorization or as specifically required or permitted by law.

I also understand that if I give permission to share my health information to someone who is legally not required to keep it confidential, it may no longer be protected by federal privacy laws.

YOUR RIGHTS
This Authorization to release health information is voluntary (not required).
Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases:

(1) To conduct research-related treatment
(2) To obtain information in connection with eligibility or enrollment in a health plan
(3) To determine an entity's obligation to pay a claim
(4) To create health information to provide to a third party

This Authorization may be withdrawn and revoked (taken back) at any time by calling Member Services at (800) 863-4155 or by mailing your signed request to:

Partnership HealthPlan of California (PHC)
c/o Member Services Department
4665 Business Center Drive
Fairfield, CA 94534
Fax: (707) 863-4415

The revocation will take effect when PHC receives it. However, your withdrawal/revocation will not affect the rights of anyone acting in reliance of this consent prior to notice of the withdrawal/revocation.

You can ask for and get a copy of this Authorization.

_____	_____
Signature	Print Name
_____	_____
Date	Relationship to Member (Self, Parent of Minor, Guardian, etc.)