AUTHORIZATION TO RELEASE PATIENT HEALTHCARE INFORMATION

4665 Business Center Drive
Fairfield, CA 94534
Fax: (707) 863-4415
www.partnershiphp.org

Redding Regional Office
3688 Avtech Parkway
Redding, CA 96002
Fax: 530-223-2508

MEMBER INFORMATION

Member's Name: ______________________________

Date of Birth (mm/dd/year): ____________________

Previous Name: ______________________________

Member ID/CIN ______________________________

I request and authorize ____ to release healthcare information of the patient named above to:

Name: ____ Phone: ________________

Address: ______________________________________

City: _________________________________ State: ________ Zip Code________________

METHOD OF RELEASE (CHECK ALL THAT APPLY)

☐ Telephone/Verbal (Telephone#) _________________ ☐ U.S. Mail/In person ☐ Fax#:_________________

THIS REQUEST AND AUTHORIZATION APPLIES TO: (Initial if applicable)

____Copies of records or medical information within the following dates: ________ to ________
____All healthcare information (except protected records)
____Records limited to a specific medical provider: ________________
____Healthcare information relating to a specific treatment or condition: ____________________
____Assistance with pharmaceutical and medical issues
____Authorization to make Primary Care Provider changes
____Other: ____

SPECIAL AUTHORIZATION FOR RELEASE OF PROTECTED RECORDS

The following information will not be released unless you authorize it by initialing next to the item below (f**or definitions for each of these items, see page three of this document**):

____Information pertaining to drug and alcohol abuse, diagnosis or treatment (42 C.F.R. §§2.34 and 2.35).
____Information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code §§5328, et seq.)
____Release of HIV/AIDS test results (Health and Safety Code §120980(g)).

EXPIRATION OF AUTHORIZATION (initial each item)

____Unless otherwise revoked, this Authorization expires ________________ (insert date).
____This authorization is valid until the member notifies PHC of the termination.
____If no date is indicated, the Authorization will expire 90 days after the date of signing this form.

______________________________	______________________________
Print Name	Signature (Member, Parent, Guardian)
______________________________	______________________________
Date	Relationship to Member (Parent, Guardian, Conservator, Member Representative)

NOTICE

Partnership HealthPlan of California and other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS

This Authorization to release health information is voluntary.

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 at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to:

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

Partnership HealthPlan of California (PHC)
c/o Member Services Department
3688 Avtech Parkway
Redding, CA 96002
Fax: 530-223-2508

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 are entitled to receive a copy of this Authorization.

DEFINITIONS

Sexually Transmitted Disease (STD) as defined by Title, 17 CCR § 2500 includes Chancroid, Lymphogranuloma venereum, Granuloma Inguinale, Syphilis, Gonorrhea, Chlamydia, Pelvic Inflammatory Disease, and Nongonococcal Urethritis

HIV/AIDS as defined by Health and Safety Code § 120775, "AIDS" means acquired immune deficiency syndrome. HIV means Human immunodeficiency virus or the etiologic virus of AIDS.

Drug or alcohol treatment as defined by Title, 22 CCR § 51341.1 includes narcotic treatment program services, outpatient drug free treatment, group counseling sessions, individual counseling, day care habilitative services, perinatal residential substance use disorder services, naltrexone treatment services,

Mental Health treatment as defined by Title 9 CCR § 1830.205 includes Pervasive Development Disorder, Disruptive Behavior and Attention Deficit Disorders, Feeding and Eating Disorders, Elimination Disorders, Schizophrenia and other Psychotic Disorders, Mood Disorders, Somatoform Disorders, Factitious Disorders, Dissociative Disorders, Paraphilias, Gender Identity Disorder, Impulse Control Disorders, Personality Disorders, Medication-Induced Movement Disorders.