



ASSIGNMENT OF AUTHORIZED REPRESENTATIVE

Important Information

You have the right to authorize (give) a friend, family member, or other person you identify access to certain medical information about you. To do this, complete this form and send it to:

Partnership HealthPlan of California Attn: Member Services – Northern Region 3688 Avtech Pkwy Redding, CA 96002 Fax: (530) 223-2508	OR	Partnership HealthPlan of California Attn: Member Services – Southern Region 4665 Business Center Drive Fairfield, CA 94534 Fax: (707) 420-7580
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Member Information

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

Authorized Representative Information

First Name:	Last Name:
Address:	
Phone Number: ()	Date of Birth:

Protected Health Information Access

Please check the box next to each type of information you want your Authorized Representative to have.

<input type="checkbox"/> Eligibility Status & Primary Care Provider	<input type="checkbox"/> Make Changes to Address & Phone Number
<input type="checkbox"/> Order ID Card	<input type="checkbox"/> Make Changes to Primary Care Provider
<input type="checkbox"/> Non-sensitive Health Information	<input type="checkbox"/> Other:

Sensitive Health Information Access (Member must sign below checkboxes)

Please check the box next to each type of information you want your Authorized Representative to have.

<input type="checkbox"/> Mental/Behavioral Health Treatment	<input type="checkbox"/> Sexually Transmitted Disease Treatment
<input type="checkbox"/> Substance Use Disorder Treatment	<input type="checkbox"/> Genetic Testing Results
Signature of Member: _____	

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: _____

Minor (12 years or older) Consent Services (Member must sign below check boxes)

Please check the box next to each type of information you want your Authorized Representative to have.

Mental Health Treatment or Counseling

Pregnancy Treatment

Assault Victim Treatment

Drug or Alcohol Treatment

Treatment for or Prevention of Sexually Transmitted or Communicable Diseases

Rape Victim Treatment

Signature of Minor Member (12 years or older): _____

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. You can revoke this Authorization by calling Member Services at (800) 863-4155 or by mailing or faxing it 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 are entitled to receive a copy of this Authorization.

Signature

Date

Print Name

Relationship to Member
(Self, Parent of Minor, Guardian, etc.)