## Authorization for Disclosure of Health Information Form

**This form is to be filled out by a member if there is a request to release the member's health information to another person or company. Please include as much information as you can.**

### Part A: Member information

| Member last name | Member first name | MI | Member date of birth |
|---|---|---|---|
| Member street address | City | State | ZIP code |

| Daytime telephone number ( ) | Cell phone number ( ) | Identification number (see identification card) |
|---|---|---|

### Part B: Person or company who will receive this information

**The following people or companies have the right to receive my information. (They must be 18 years of age or older). Please enter first and last name. By entering first/last name below that person may receive my information.**

| | |
|---|---|
| **My spouse** (enter first and last name) | **My parents** (if you are over 18 — enter first and last name[s]) |
| **My domestic partner** (enter first and last name) | **My insurance broker or agent** (enter the name of the company and first and last name, if you have it) |
| **My adult children** (enter first and last name[s]) | **Other** (enter first and last name [if you have it], name of company, and how it's related to you) |

### Part C: Information that can be released

**I allow the following information to be used or released by Delta Health Systems (DHS) on my behalf:**

**Check only one box.**

☐ **All my information. This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.**

**OR**

☐ **Only limited information may be released (check all boxes below that apply to you).**

- ☐ **Appeal**
- ☐ **Benefits and coverage**
- ☐ **Billing**
- ☐ **Claims and payment**
- ☐ **Diagnosis (name of illness or condition) and procedure (treatment)**
- ☐ **Doctor and hospital**
- ☐ **Eligibility and enrollment**
- ☐ **Financial**
- ☐ **Medical records**
- ☐ **Pre-certification and pre-authorization (for treatment approvals)**
- ☐ **Referral**
- ☐ **Treatment**
- ☐ **Dental**
- ☐ **Vision**
- ☐ **Pharmacy**
- ☐ **Other: _____**

**I also approve the release of the following types of sensitive information by DHS (check all boxes that apply to you):**

☐ **All sensitive information[2] OR** ☐ **Just information about topics checked below**

- ☐ **Abortion**
- ☐ **Abuse (sexual/physical/mental)**
- ☐ **Substance use disorder[1,2]**
- ☐ **Genetic testing**
- ☐ **HIV or AIDS**
- ☐ **Maternity**
- ☐ **Mental health**
- ☐ **Sexually transmitted illness**
- ☐ **Other:_____**

1 Specify time period of records to be disclosed: _____

Description of records that may be disclosed: _____

2 Unless I specify otherwise on this form, I intend this disclosure to include all substance use disorder records maintained by DHS about me. I understand that my substance use disorder records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time, or as described in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

## Part D: Purpose of this approval — Check only one box.

☐ To give out the information as shown on this form.

OR

☐ For this reason(s):_____

## Part E: Date your approval expires — Check only one box.

If this document was not already withdrawn, this approval will end on the earliest of the following dates:

☐ For spouses, 5 years of signature date

OR

☐ For underage dependents, upon their 26th birthdate

## Part F: Review and approval

I have read the contents of this form. I understand, agree, and allow DHS to the use and release of my information as I have stated above or as required by applicable law. I also understand that signing this form is of my own free will. I understand that DHS does not require that I sign this form for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to DHS. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Member signature or Designated Legal Representative/Guardian signature — Date

X

**Legal Representative/Guardian – Complete this section only if you have documentation supporting Legal Representation.**

If this form is signed by someone other than the member or parent, such as a personal representative, legal representative, or guardian on behalf of the member, please submit the following:

A copy of a health care, general or Durable Power of Attorney.

OR

A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

Please complete the following:

| Legal representative (print full name) | Legal relationship to member |
|---|---|
| | |

| Legal representative street address | City | State | ZIP code |
|---|---|---|---|
| | | | |

| Signature | Date |
|---|---|
| X | |

Please return the completed form to:

Delta Health Systems
P.O. Box 80
Stockton, CA 95201-3080

by fax: (209) 474-5407
or by email: delta.supportservices1@delapro.com
Be sure to keep a copy of this form for your records.

## For recipient of substance use disorder information

This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any patient with a diagnosis of substance use disorder.