



## Authorization for Disclosure of Protected Health Information

Completion of this document authorizes Vitality Health Plan of California (“VHP”), to use or disclose my protected health information (PHI) as described below:

<i>Section I. Individual whose information will be disclosed</i>				
Name:	Member ID number:	Date of birth:		
Address:				
City:	State:	ZIP:	Phone number:	
<i>Section II. Description of information to be disclosed</i>				
<i>I authorize VHP to disclose the following types of health information.</i>				
<b>A. General description of health information (please select all that apply):</b>				
<input type="checkbox"/> Application, enrollment, membership, and eligibility records and information				
<input type="checkbox"/> Claims/Explanation of Benefits/Evidence of Coverage records and information				
<input type="checkbox"/> Pharmacy records and information				
<input type="checkbox"/> Premium/payment/billing information and records				
<input type="checkbox"/> Other information (please describe): _____				
<b>B. Additional description of sensitive information categories (please select all that apply):</b>				
You must complete this section to authorize the release of information and records regarding the following sensitive information categories:				
<input type="checkbox"/> Drug or alcohol abuse diagnosis, treatment, prognosis, or referral				
<input type="checkbox"/> HIV/AIDS (including AIDS-related complex (ARC)) or sexually transmitted diseases (STDs)				
<input type="checkbox"/> Genetic testing				
<input type="checkbox"/> Mental or behavioral health services				
<i>Section III. Purpose</i>				
<i>I authorize VHP to disclose the information identified above for the following purpose(s):</i>				
<input type="checkbox"/> At my request				
<input type="checkbox"/> Other (please specify): _____				
<i>Section IV. Expiration of authorization</i>				
This authorization will expire on _____ (mm/dd/yy).				
If no date is provided, this authorization will expire in one year.				
<i>Section V. Person or entity to receive information</i>				
<i>I authorize disclosure of my health information as indicated above to the following:</i>				
Name:		Company (if applicable):		
City:	State:	ZIP:	Phone number:	
Name:		Company (if applicable):		
City:	State:	ZIP:	Phone number:	

*Section VI. Important information*

- Information disclosed based on this authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations, including HIPAA.
- I may revoke this authorization in writing by sending a written notice to the VHP Privacy Officer at 18000 Studebaker Rd., Suite 960, Cerritos, CA 90703. My revocation will be effective upon receipt but will not be effective to the extent that VHP or others have acted in reliance upon this authorization.
- Treatment, payment, enrollment, or eligibility for benefits are not conditioned on my providing or refusing to provide this authorization, unless I have not yet enrolled with VHP and VHP is seeking to obtain information in connection with determining my eligibility for benefits or enrollment, or unless VHP is requesting the information for underwriting or risk rating purposes.
- I have a right to receive a copy of this authorization. A copy is as valid as the original.

*Section VII. Acknowledgment*

**By signing this authorization, I acknowledge that I have read and understand the above information, and that my signature authorizes the disclosure of the information described above.**

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(Signature of member or personal representative)

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Date

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(Printed name of member, or personal representative)

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(Relationship – description of authority to act on behalf of the member, if applicable)

If this authorization is signed by anyone other than the member, VHP may require verification of the individual's authority to act on behalf of the member before any PHI is disclosed pursuant to this authorization.