



State of California—Health and Human Services Agency
Department of Health Care Services



AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

This document authorizes the Department to disclose and discuss health information about you or the person you represent with the Legislator and the member(s) of his or her staff assigned to assist with your problem. Unless otherwise indicated below, this authorization does not authorize the disclosure of HIV information, mental health treatment information, or alcohol or drug treatment information. Treatment, payment, enrollment in a health plan, and eligibility for benefits will not be affected if you do not sign this authorization.

_____ *Print Full Name of Beneficiary or Plan Member*

OR

_____ on behalf of _____
Print Name of Representative *Print Name of Beneficiary or Plan Member*

authorizes the Department of Health Care Services to communicate with and disclose medical information you specify on this form to the office of :

_____ *Print Name of Legislator*

Briefly describe the problem that led you to contact your Legislator’s Office?

I specifically authorize the release of the following information (check and initial as appropriate):

Mental health treatment information : (initial) _____

If you check either of the following boxes, you will be required to fill out a different form:

HIV information : (initial) _____

Alcohol/drug treatment information : (initial) _____

This authorization is in effect until the following date _____, or the resolution of the problem described above, after which this authorization expires.

I understand that by signing this authorization:

▲ I authorize the use and disclosure of the health information described on this form only for the purpose(s) stated.

▲ I have the right to receive a copy of this authorization.

▲ I have the right to revoke this authorization at any time by sending a written notice to the Department of Health Care Services, Office of Legislative and Governmental Affairs at the address listed at the bottom of the first page of this authorization.

▲ My revocation is effective upon receipt, except it does not apply to uses and disclosures before it takes effect.

▲ I understand that health information disclosed through the authorization is no longer protected and could be disclosed to another entity.

Please fill in the Beneficiary/ Plan Member Information and sign on the next page.

Beneficiary/Plan Member Information

<i>Last Name</i>		<i>First Name</i>	<i>Middle Initial</i>
<i>Address</i>		<i>City/State</i>	<i>Zip Code</i>
<i>Benefits Id Number</i>		<i>Email Address</i>	
<i>Date Of Birth</i>	<i>Date Of Death</i>	<i>Home Phone Number</i>	<i>Work Phone Number</i>

If you are the Representative of a Beneficiary or Plan Member, please fill in your information and provide a copy of the written legal authority showing that you are authorized to act on behalf of the beneficiary or plan member. If the plan member or beneficiary is deceased, please provide a copy of the death certificate.

Printed Name

Relationship to Beneficiary

Address

E-mail

City, State, Zip Code

Telephone Number

Indicate Your Relationship – Please Attach Written Legal Authority

- PARENT OF MINOR CHILD ATTORNEY AT LAW
- GUARDIAN CONSERVATOR EXECUTOR/ADMINISTRATOR
- HEALTHCARE POWER OF ATTORNEY OTHER: _____

Please sign the authorization.

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

SIGNATURE _____ **DATE** _____