



## AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

Please complete this Authorization to Release Confidential Medical Information form to authorize Health Net to disclose your confidential personal information with the individual or organization you identify on this form. This Authorization is voluntary. We will not condition payment, enrollment in our health plan, or eligibility for benefits on you giving this Authorization.

### INFORMATION TO BE DISCLOSED

I authorize Health Net of Arizona and/or Health Net Life Insurance Company (Health Net) to disclose the following information: (please check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Application, Enrollment, Eligibility Information | <input type="checkbox"/> Transition of Care Information |
| <input type="checkbox"/> Claims/Explanation of Benefit Information        | <input type="checkbox"/> Pharmacy Information           |
| <input type="checkbox"/> Prior Authorization                              | <input type="checkbox"/> Medical Records                |
| <input type="checkbox"/> Premium Billing/Payment Information              | <input type="checkbox"/> Account Information            |

☐ I authorize Health Net of Arizona to release information that may include record of drug, alcohol and/or psychiatric treatment.

☐ I authorize Health Net to release confidential HIV/AIDS related information including AIDS Related Complex (ARC) or confidential communicable disease related information.

### PURPOSE OF DISCLOSURE/USE

- |   |   |
|---|---|
| <input type="checkbox"/> Assist with obtaining a health care policy | <input type="checkbox"/> Assist with account/premium reconciliation |
| <input type="checkbox"/> Assist with claims processing/payment      | <input type="checkbox"/> Other: _____                               |

### PERSON WHOSE INFORMATION MAY BE RELEASED

Name: \_\_\_\_\_

### PERSON TO WHOM INFORMATION MAY BE DISCLOSED

Name: \_\_\_\_\_

Agency/Company: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, ZIP: \_\_\_\_\_

General Agency: \_\_\_\_\_

### DURATION OF AUTHORITY

This Authorization is effective immediately and will expire 180 days from the date the form is signed. You may revoke this Authorization by giving written notice to IFP Underwriting Department, 1230 W. Washington, Suite 401, Tempe, Arizona 85281, but any revocation will not apply to any action Health Net takes in reliance on this Authorization prior to revocation. You are entitled to a copy of this Authorization. You may refuse to sign this Authorization. It is possible for the confidential information disclosed pursuant to this Authorization to be subject to redisclosure by the recipient and no longer protected by the federal health information privacy regulations. Health Net shall not be responsible for any such disclosure, whether or not permitted by law.

Print name (member/applicant or authorized representative): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship (if signed by other than member/applicant): \_\_\_\_\_

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