Health Net®

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)

__ Application, Enrollment, Eligibility Information
__ Claims/Explanation of Benefit Information
__ Prior Authorization
__ Premium Billing/Payment Information
__ Transition of Care Information
__ Pharmacy Information
__ Medical Records
__ 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

__ Assist with obtaining a health care policy
__ Assist with claims processing/payment
__ Assist with account/premium reconciliation
__ 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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