Return To: Member Services
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017
Toll-free FAX: 844-657-7272
For Questions - *Medi-Cal: 888-839-9909*
LACC: 855-270-2327
PASC: 844-854-7272
CMC: 888-522-1298

AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION FORM

Part I of this form lets L.A. Care use or share your Protected Health Information ("PHI") with others. Part II of this form lets you name someone else to act on your behalf. Please fill out this form and send it to the address above.

PART I

SECTION A: MEMBER INFORMATION		
Member Name:		
Member Address:		
City:	State:	Zip Code:
Date of Birth:		
Member ID#:		
Phone:		

SECTION B: AUTHORIZATION TO USE/RELEASE PHI
By filling out Section B, I am letting L.A. Care and its affiliates use or share my PHI with the person or agency below. I know this authorization starts when I sign and return this form.
Name:
Agency Name (if applicable):
Address:
City/State/Zip:
Date of Birth:
Phone:

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SECTION C: TYPE OF INFORMATION

By filling out Section C, I am telling L.A. Care and its affiliates what types of PHI they may use or share with the name/agency listed in Section B. *(Check all that apply.)*

- ☐ Medical Information *(e.g., Authorization Requests, Care Management Records, etc.)*
- ☐ Claims Information *(e.g., Pharmacy, Hospital, or Provider Claim Records, etc.)*
- ☐ Financial Information *(e.g., Premium Payment Information, etc.)*
- ☐ Enrollment Information *(e.g., Enrollment Form, Enrollment Dates, etc.)*
- ☐ HIV Test Results
- ☐ Mental Health Treatment Information
- ☐ Alcohol/Drug Treatment Information
- ☐ Other (please specify):

SECTION D: PURPOSE

Please describe the purpose or reason for sharing or using PHI.

- ☐ Legal
- ☐ Insurance
- ☐ Personal Use
- ☐ Other (please specify):

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SECTION E: EXPIRATION DATE

By filling out Section E, I am letting L.A. Care know when my PHI can no longer be used or shared with others. *(Check one).*

- ☐ After one year from today's date.
- ☐ After I disenroll or are no longer covered by L.A. Care
- ☐ As of this date (month, day, and year):

SECTION F: RIGHT TO REVOKE

You may stop this authorization at any time. To do this, send a letter to:

Customer Solutions Center
L.A. Care Health Plan
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017
Toll-free Fax: 1-844-657-7272

Sending a letter to stop this authorization will not change how L.A. Care used or shared your PHI before getting your letter.

SECTION G: RESTRICTIONS

The person who gets PHI from L.A. Care may show it to others. In this case, your PHI may no longer be protected by HIPAA Privacy Rules.

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SECTION H: MEMBER RIGHTS
You have the right to look at or get a copy of your PHI that is being used or shared by this authorization. You can stop this authorization at any time. *(See Section F).* You do not have to fill out this form. Not filling out this form will not affect your ability to sign up with L.A. Care, obtain benefits, or receive payment of your claims. You have the right to get a copy of this authorization.

SECTION I: SIGNATURE
By signing Section I, I am letting L.A. Care share the PHI checked in Section C with the person/agency in Section B. I have read this form and I know what it means.
Today's Date:
Signature of member or personal representative:
If representative, give relationship:

STOP

If you only want L.A. Care to share PHI with the name/agency in Section B, sign Section I and send this form back to L.A. Care's Privacy Officer at the address listed on the top right hand corner.

If you also want to let someone act on your behalf (such as changing your doctor or helping with a complaint), move on to the next page.

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PART II

Part II lets you name someone else, such as a family member, to act on your behalf, even if you can do so yourself. If you do not want someone to act on your behalf, but are okay with us sharing PHI with them, just complete Part I and send it to the address listed in the top right hand corner.

SECTION J: AUTHORIZATION TO ACT ON MY BEHALF

By filling out Section J, I am letting these person(s) act on my behalf for the things listed in Section K. I know this appointment starts when I sign and return this form.

Name:

Agency Name (if applicable):

Address:

City/State/Zip:

Date of Birth:

Phone:

Name:

Agency Name (if applicable):

Address:

City/State/Zip:

Date of Birth:

Phone:

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SECTION K: APPOINTED DUTIES

By filling out Section K, I am letting the person(s) in Section J act on my behalf to make changes to: *(Check all that apply).*

- ☐ Medical Information *(e.g., assist with authorization requests, care management, etc.)*
- ☐ Claims Information *(e.g., assist with claims issues, etc.)*
- ☐ Financial Information *(e.g., change my premium payment information, etc.)*
- ☐ Enrollment Information *(e.g., change my medical provider, medical group or health plan, etc.)*
- ☐ Other (please specify):

SECTION L: APPOINTMENT EXPIRATION DATE

By filling out Section L, I am letting L.A. Care know when the person(s) in Section J can no longer act on my behalf. *(Check one).*

- ☐ The person in Section J can no longer act on my behalf after one year from today's date
- ☐ The person in Section J can no longer act on my behalf after I disenroll or am no longer covered by L.A. Care
- ☐ The person(s) in Section J can no longer act on my behalf as of this date (month, day, and year):

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SECTION M: RESTRICTIONS

Filling out Part I of this form lets L.A. Care share your PHI. Filling out Part II of this form lets the person(s) named in Section J act on your behalf. L.A. Care may not ask you for your okay before letting the person(s) named in Section J act on your behalf.

SECTION N: RIGHT TO REVOKE

You may stop letting the person(s) in Section J act on your behalf at any time. To do this, send a letter to:

Customer Solutions Center
L.A. Care Health Plan
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017
Toll-free Fax: 1-844-657-7272

SECTION O: SIGNATURE

By signing Section O, I am allowing the person(s) named in Section J to act on my behalf for the duties listed in Section K.

Today's Date:

Signature of member or personal representative:

If representative, give relationship: