# AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

Please complete this Authorization to Release Confidential Medical Information form if you would like Health Net to share your personal information with the individual or organization specified on this form.

## AUTHORIZATION

I authorize Health Net of Arizona, Inc. and/or Health Net Life Insurance Company (Health Net), to furnish

[name of broker or other individual]

with medical records and information pertaining to
[name of member/applicant]

This authorization is limited to the following medical records and type of information:

- ☐ Claims
- ☐ Prior Authorization
- ☐ Pharmacy
- ☐ Premium Billing
- ☐ Transition of Care
- ☐ Other (please describe) _____

## USE

The person designated above is authorized to use these medical records and information solely for the following purposes:

(Check all that apply)

- ☐ Health care issues
- ☐ Billing reconciliation
- ☐ Obtaining a health care policy
- ☐ Other (please describe) _____

## DURATION OF USE

This authorization is effective immediately and remains in effect for ninety (90) days after the expiration or termination of my Health Net coverage unless otherwise requested.

## NOTICE

Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and is no longer protected by the federal health information privacy laws.

## MY RIGHTS

I may revoke this authorization at any time as indicated in Health Net's Notice of Privacy Practices. I have the right to receive a copy of this authorization.

Neither payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. This restriction does not apply if Health Net is seeking to obtain information in connection with my eligibility or enrollment in a Health Net plan if I am not already a member, or to obtain information required for payment of a specific claim for benefits.

Print name

(member/applicant or duly authorized representative)

Signature Date

Indicate relationship if signed by other than member or applicant

Health Net®
A Better Decision



AZ38415 (3/07)