



Authorization to Disclose Medical Information

Please complete with Black or Blue Ink or Type

Patient's Last Name	First Name	M.I.
Subscriber's I.D. Number		

This authorization for use or disclosure of medical information is being requested of you to comply with the requirements of the California Confidentiality of Medical Information Act and Civil Code 56 et seq. Health information is not sought for the purposes of selling or marketing.

I hereby authorize disclosure of my medical information under the following conditions and limitations:

1. Information may be disclosed to:	Name of person or entity to whom information may be disclosed
2. Information may be disclosed by:	Name or function of person or entity authorized to disclose information
3. Information that may be disclosed:	State type(s) of information that may be disclosed
4. Uses and limitations on information:	State specific uses and limitations to information by recipient
5. Expiration date of authorization:	State date on which authorization for use of information expires. Should an actual date not be provided, Health Net Dental and Vision will accept this signed form for one year from date of signature _____ / _____ / _____

6. Authorization granted by: (print name) _____

Relationship to patient: _____

Patient, spouse, legal representative, or beneficiary (Patient's spouse may authorize disclosure of the patient's medical information **only** when the medical information is for the sole purpose of processing an application for health insurance, for enrollment in a health care service plan or an employee benefit plan, and where the patient is to be an enrolled spouse or dependent under the policy or plan).

Signature: _____ Date: ____/____/____

Completion and signature of this Authorization Form cannot be made a condition for treatment or payment to the concerned patient.

***** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION *****

Patient or other party signing this Authorization Form has a right to receive a copy of the Form. Authorization can be cancelled / modified by written notice of authorizing person.

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

INSTRUCTIONS ON COMPLETING THIS FORM

This form must be completed, in full, to authorize Health Net Dental and Vision to release any of your personal medical information to any person or entity other than yourself or your legal representative.

Line 1: Insert name of person or organization to whom you authorize Health Net Dental and Vision to release your personal medical information.

Example: Mr. John Doe – (your spouse)

Line 2: Insert the name of person or organization holding the personal medical information that you wish to disclose to the person or organization you listed on Line 1.

Example: For information held by **Health Net Dental and Vision**, insert that name on this line.

Line 3: Specify the information that you authorize to be released.

Example: Dental records, X-rays, medical history, medications used.

Line 4: Specify what the person or organization listed on Line 1 can use the information (listed on line 3) for, and list any limitations on that use.

Example: Determine benefits, authorize specialty referral.

Line 5: Insert the date when you want this Authorization (specified on Line 3) to expire.

Line 6: Print your Name

Insert your relationship to the patient:

Example: The Patient

Signature: Sign the Authorization Form and date it.

Please read the Notes contained in boxes on the form. They advise you of your rights.

When you have completed this form, please send to:

Health Net Dental and Vision
P.O. Box 57074
Irvine, CA 92619-7074

For questions related to completing this Authorization Form, contact the Customer Service Department at (800) 999-2848, Ext.300.