Authorization for Use and Disclosure of Protected Health Information

Please complete this form if you wish to authorize Sutter Health Plan to disclose your protected health information to another individual or entity. This authorization is voluntary. Sutter Health Plan will not condition payment, enrollment in our health plan, or your eligibility for benefits on your signing this authorization.

Email, fax or mail your completed form to:

EMAIL
shpserviceteam@sutterhealth.org

FAX
916-736-5426

MAIL
Sutter Health Plan
P.O. Box 160345
Sacramento, CA 95816

Section A – Member Information (person whose information will be disclosed)

Member ID Number

Last Name | **First Name** | **MI** | **Date of Birth**

Residential Address | **City** | **State** | **ZIP**

Phone | **Email** (optional)

Section B – Recipient (person or company authorized to receive the member's information)

Name of Individual or Organization

Address | **City** | **State** | **ZIP**

Relationship to Member

Section C – Purpose for This Requested Disclosure

☐ **The information is about me and is to be used or disclosed at my request**

☐ **For this reason(s):**

Sutter Health Plan

Section D – Information To Be Disclosed

☐ **My Complete Health Plan Record.** This may include health information, diagnosis information, claims, payment, identification of doctors and other healthcare providers, and information they have provided. This does not include the sensitive information listed below unless specifically authorized by checking the box and initialing below.

OR

☐ **Only limited information may be released** (check all that apply)

Claims and explanation of benefits information

Application, eligibility and enrollment (including member ID information)

Benefits and coverage

Billing and payment information

Other: _____

I also approve the release of the following types of sensitive information by Sutter Health Plan (check one)

☐ **All of my sensitive information** (including HIV test results, substance abuse information, mental health information, and genetic testing information and results)

_____ (initial)

OR

☐ **Just information about the topics below** (check all that apply)

HIV test results _____ (initial)

Substance abuse _____ (initial)

Mental health _____ (initial)

Genetic testing information/results _____ (initial)

I would like to limit this release to information related to the following date(s) of service for records requested:

_____

Section E – Expiration and Revocation

This authorization shall become effective immediately and shall remain in effect for one year from the date signed unless a different date is specified here _____.

You may revoke your authorization at any time. Your revocation must be in writing, signed and delivered via our secure fax line at **916-736-5426**, by email to **shpserviceteam@sutterhealth.org** or by mail to the address indicated at the bottom of the form.

Revocation will be effective upon receipt, but will have no impact on uses or disclosures made while your authorization was valid.

Section F – Signature

I, _____, understand that by signing this authorization I am voluntarily giving my permission to Sutter Health Plan to disclose my protected health information to the recipient(s) identified above. I understand that I may refuse to sign this authorization and my refusal will not affect enrollment or eligibility for benefits, or my ability to obtain treatment or payment. I understand that I may revoke this authorization at any time. I understand that I have a right to receive a copy of this authorization and that I have a right to request to inspect and obtain a copy of the information of which I am authorizing the use or disclosure. I understand that once my information is disclosed, it could be redisclosed by the recipient and may no longer be protected by state or federal privacy laws. I understand that Sutter Health Plan will not be responsible for any redisclosure, whether or not permitted by law.

Member/Legal Representative Signature **Date** **Time**

If signed by someone other than the member, print name and relationship. Sutter Health Plan may require documentation showing your legal authority to act on behalf of the member before acting upon this authorization.

Name **Relationship**