MEMBER ID: _____

AUTHORIZATION FORM

PATIENT'S NAME: _____

INFORMATION TO BE DISCLOSED: (insert description of health information to be disclosed (e.g., patient's diagnosis, treatment or coverage information)

☐ All Protected Health Information

PURPOSE OF THE DISCLOSURE: (describe all purposes for the disclosure. Not required if information is to be disclosed only to the Plan participant)

_____

_____

_____

PHI TO BE DISCLOSED BY: PHI TO BE DISCLOSED TO:

Foundation for Medical Care _____

ACKNOWLEDGEMENTS

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my eligibility for Plan benefits or my ability to obtain treatment or payment.

If this authorization is for the Plan's eligibility or enrollment determinations related to me or for underwriting or risk rating determinations, I understand that I may refuse to sign this authorization but that, if I do not sign, the Plan may refuse to enroll me.

I understand that I may revoke this authorization, at any time, by sending a written request to the privacy contact identified below. I am aware that a revocation will not have any affect on any use or disclosure of Protected Health Information (PHI) by the Plan before it receives the revocation.

Foundation for Medical Care
3335 South Fairway
Visalia, CA 93277

This authorization expires on _____ or
☐ until revoked in writing.

I understand that if Protected Health Information about me is disclosed to a person or organization that is required to comply with federal privacy regulations, the information may be re-disclosed and is not protected by the federal privacy regulations.

SIGNATURE OF PATIENT (or parent if a minor or patients' personal representative – (see NOTE)

_____

Signature Date

NOTE: If this authorization is signed by the patient's personal representative, attach a statement of the representative's authority to act on behalf of the individual.

SI
BC