



Authorization for Use and/or Disclosure of Protected Health Information (PHI)

This form authorizes Kern County Health & Wellness to use and/or disclose your PHI to the individuals that you have specified below. For the purpose of this form, PHI is considered as individually identifiable health information received or maintained by Kern County Health & Wellness. Without a completed and signed authorization form, Federal law prohibits Kern County Health & Wellness from releasing your PHI to your spouse, parents, adult children, other family members, or friends unless you are present at the time of disclosure.

SECTION A: Individual Authorizing Use and/or Disclosure:

Member Name:					
Member ID:		Date of Birth:			
Address:					
City:		State:		Zip:	
Phone Number:			Date of Request:		

SECTION B: Person(s) You Are Authorizing Kern Legacy Health Plans to release your PHI to:

I authorize my Kern County Health & Wellness to release information to:					
1) Name of Provider Organization or Person:					
Relationship to Member:		Phone Number:			
Address:					
City:		State:		Zip:	
2) Name of Provider Organization or Person:					
Relationship to Member:		Phone Number:			
Address:					
City:		State:		Zip:	
3) Name of Provider Organization or Person:					
Relationship to Member:		Phone Number:			
Address:					
City:		State:		Zip:	

SECTION C: Purpose of This Use and/or Disclosure (check all boxes that apply):

<input type="checkbox"/>	Authorizations for health care, pharmacy, dental and vision services
<input type="checkbox"/>	Claims, benefit coverage and eligibility
<input type="checkbox"/>	Health plan member reimbursements
<input type="checkbox"/>	Other (please specify):

SECTION D: *I Understand That:*

- My right to healthcare is not conditioned on this authorization.
- I may cancel/revoke this authorization at any time by submitting a written request to Kern County Health & Wellness, however; the cancelation will not have any effect on any actions that Kern County Health & Wellness took prior to receiving the revocation.
- If the person or facility receiving this information is not a healthcare or medical insurance provider covered by the privacy regulations, the information stated above may be re-disclosed
- A recipient of medical information in California may not further disclose medical information about me (the member) unless a new authorization form is signed by myself or my personal representative or unless the disclosure is specifically required or permitted by law.

SECTION E: *Expiration and Right to Revoke*

This authorization will expire. You may choose an expiration date or give an expiration event that relates to the purpose of this release (i.e., when I retire; upon disenrollment of the plan). If a date or event is not entered, this authorization will automatically expire in one year from the date of the request.

Date of expiration:	
Expiration event:	

I understand that I may cancel/revoke this authorization at any time by giving written notice to Kern County Health & Wellness. I can mail or drop off my notice of revocation to:

Kern County Health & Wellness
 1115 Truxtun Avenue, 1st Floor
 Bakersfield CA 93301
 (661) 868-3182

SECTION F: *Signature of member or authorized representative*

I, _____, have had full opportunity to read and consider the contents of this authorization.
MEMBER'S NAME

I understand that by signing this form, I am confirming my authorization that is allowing Kern County Health & Wellness to release the protected health information described in this form for the purposes stated in this form.

Member's Signature: _____ **Date:** _____

Signature of an authorized Representative (if applicable)

Authorized representative means you have legal proof that you are authorized to act for this person. An authorized representative signs for a plan member who may not legally sign on his or her own. If the member is less than 18 years old, a parent or guardian should sign for the minor. We must have the legal documentation of your appointment on file with this authorization form.

Authorized Representative's Name: _____ **Relationship:** _____

Authorized Representative's Signature: _____ **Date:** _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT



For Office Use Only:		
Effective Date:	Expiration Date:	Initials: