Sutter Health Plus
Your Health Plan

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATON

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

Return the completed form to Sutter Health Plus via our secure fax line at 1-916-736-5426, by email to *shpenrollmentmailbox@sutterhealth.org* or by mail to: P.O. Box 160345, Sacramento, CA 95816.

MEMBER INFORMATION (person whose information will be disclosed)

Member Name: _____ DOB: _____ ID: _____

Address: _____ City: _____ State: ____ ZIP: _____

Phone: _____ Email (optional): _____

RECIPIENT (person or company authorized to receive the member's information

Name of Individual or Organization: _____

Address: _____ City: _____ State: ____ ZIP: _____

Relationship to Member: _____

PURPOSE FOR THIS REQUESTED DISCLOSURE (check one)

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

☐ For this reason(s): _____

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 Plus (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: _____

_____.

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 you authorization at any time. Your revocation must be in writing, signed, and delivered via our secure fax line at 1-916-736-5426, by email to *shpenrollmentmailbox@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 my authorization was valid.

SIGNATURE:

I, _____, understand that by signing this authorization I am voluntarily giving my permission to Sutter Health Plus 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 Plus will not be responsible for any redisclosure, whether or not permitted by law.

SIGNATURE: _____ Date: _____ Time: _____

(Member/Legal Representative)

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

Name: _____ Relationship: _____

Notice of Language Assistance

IMPORTANT: Can you read this? If not, Sutter Health Plus can have somebody help you read it. You may also be able to get this written in your language. For no-cost help, please call Sutter Health Plus Member Services at 1-855-315-5800 (TTY 1-855-830-3500). (English)

IMPORTANTE: ¿Puede leer esto? Si no puede, Sutter Health Plus puede proporcionarle alguien que le ayude a leerlo. También puede obtenerlo por escrito en su idioma. Llame a Sutter Health Plus Member Services al 1-855-315-5800 (TTY 1-855-830-3500), sin costo alguno. (Spanish)

重要提示：您能讀懂這份文件嗎？如果不能，Sutter Health Plus 可以找人幫助您讀它。您還可能得到用您的語言書寫的這份文件。若需要免費幫助，請致電 Sutter Health Plus 會員服務，電話號碼 1-855-315-5800 (TTY 1-855-830-3500)。(Chinese)