

**AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF  
PROTECTED HEALTH INFORMATION (“PHI”)**

The authorization for use and disclosure of medical information is being requested of you to comply with the terms of the federal HIPAA privacy regulations, 45 C.F.R. 164.508

PLEASE PRINT CLEARLY

Member Name: \_\_\_\_\_  
  **LAST**  **FIRST**  **INITIAL**

Address: \_\_\_\_\_  
  **STREET**  **CITY**  **STATE**  **ZIP**

Phone (\_\_\_\_) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Member ID# \_\_\_\_\_ Health Plan \_\_\_\_\_

1. I authorize the use or disclosure of the above named individual’s Protected Health Information as described below.

“All medical issues pertaining to claims, authorizations, bills and treatment”

2. The following individual or organization is authorized to make the disclosure:

North American Medical Management California, Inc./PrimeCare Medical Network, Inc., or any affiliated IPA thereto.

3. This information may be disclosed to and used by the following individual or organization:

Name: \_\_\_\_\_

4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: \_\_\_\_\_.  
If I fail to specify an expiration date, event or condition, this authorization will not expire.

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5. I understand that authorizing the disclosure of this PHI is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

\_\_\_\_\_  
Signature of Member or \*Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If not Member, state relationship

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

**\*By signing this form, I represent that I am the legal representative of the member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the member’s behalf with respect to this authorization form.**