



Health Net of the Northeast,
Inc.
One Far Mill Crossing
P.O. Box 904
Shelton, CT 06484-0944
www.health.net

Health Net
Authorization for Disclosure of Health Information

- (1) I hereby authorize Health Net to disclose the following information from the health records of

Member Name _____ Date of Birth _____
Address _____ Telephone _____
_____ Member ID# _____

covering the period(s) of healthcare

From(date) _____
To(date) _____
From(date) _____
To(date) _____

- (2) Information to be disclosed
- | | |
|---|--|
| <input type="checkbox"/> complete health record(s) | <input type="checkbox"/> discharge summary |
| <input type="checkbox"/> history & physical examination | <input type="checkbox"/> progress notes |
| <input type="checkbox"/> claim information | <input type="checkbox"/> laboratory tests |
| <input type="checkbox"/> benefit information | <input type="checkbox"/> other |

(please specify) _____

Check if disclosure shall include information relating to:

- Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection
 Behavioral health services/psychiatric care
 Treatment for alcohol and/or drug abuse

If boxes are not checked, no such information shall be released.

In the Northeast, coverage is provided by subsidiaries of Health Net of the Northeast, Inc. and Health Net of Pennsylvania, Inc.

(3) This information is to be disclosed to _____ for the purpose of _____

(4) Unless otherwise revoked, this authorization shall become effective immediately and shall remain in effect until (date) _____, event, condition: _____ month/day/year

(5) I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization.

(6) Additional Copy. I understand that I have a right to receive a copy of this authorization upon my request

Copy requested and received: Yes _____ No _____ _____
Member initial

(7) Health Net, its employees and officers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

(8) Information used or disclosed pursuant to an authorization may be subject to redisclosure by the recipient and no longer protected by the federal health information privacy regulations.

(9) Neither payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. This restriction does not apply if Health Net is seeking to obtain information in connection with my eligibility or enrollment in Health Net when I am not already a member or to obtain information required for payment of a specific claim for benefits.

Signed:

Member Date

or Legal Representative Relationship to Member Date

Signature of Witness Relationship to Member Date

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