Authorization To Disclose
Protected Health Information (PHI)

COMMUNITY CARE HEALTH

Name: _____ Date of Birth: _____

Community Care Health ID#: _____

I hereby authorize Community Care Health to disclose the following information to the person and/or entity listed below:

- ☐ Enrollment, Eligibility, Benefits
- ☐ Medical Records and Diagnosis
- ☐ Alcohol/Substance Abuse
- ☐ Preauthorization
- ☐ Claims, Claim Status, Claim History
- ☐ Premium and Billing Information
- ☐ Appeal
- ☐ Other _____

Information released may contain personal facts, including personal information related to the treatment of sexually transmitted diseases, HIV/AIDS, mental health and reproduction or contraception (including prenatal care and abortion).

Name _____ Relationship _____

Address _____ Phone _____

I acknowledge that I may cancel this Authorization at any time by sending written notice to Community Care Health, PO Box 45026, Fresno, CA 93718

Cancellation of this authorization will not affect any action taken by Community Care Health before receiving cancellation notice. I understand completing this Authorization is not a condition to receiving treatment, payment, enrollment, or eligibility.

Community Care Health is not responsible for any action taken by authorized recipient of Protected Health Information (PHI). I am aware that once Community Care Health discloses my information to an authorized recipient, privacy protections provided by law may no longer apply.

X _____ _____
Signature Date

Please return form by mail to: Community Care Health, PO Box 45026, Fresno CA 93718
Fax: (559) 599-0022 or Email: customerservice@communitycarehealth.org

This Authorization Will Expire Two (2) Years from Date Signed