DELTA HEALTH SYSTEMS
Administration Services

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

The Health Insurance Portability and Accountability Act requires that Delta Health Systems have permission to disclose protected health information in certain cases.

All sections of this form must be thoroughly completed before Delta Health Systems is permitted to honor the authorization. After you complete the form, mail it to:

Delta Health Systems | P.O. Box 80 | Stockton, CA 95201-3080
You may also fax the form to: (209) 939-3930

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1. Give a specific description of the protected health information to be disclosed:

2. Indicate the reason(s) that the protected health information is to be shared, or write 'at the request of the individual':

3. Indicate who the individual is that is requesting that the protected health information be shared (check one):

☐ Plan participant

☐ Personal representative of plan participant. Examples: parent or legal guardian of a minor child.

4. Provide the specific uses and/or limitations on the information to be disclosed:

5. List the individual(s) or company that has permission to receive the protected health information:

☐ Your parent. Name(s): _____

☐ Your spouse or domestic partner. Name(s): _____

☐ Other–please indicate below.

Name:_____ Relationship: _____

Mailing Address: _____

6. Provide the specific uses and/or limitations on the recipients' use of the information:

7. Indicate the date you wish this authorization to expire. If you do not wish to indicate an expiration date, write 'none':_____

You have the right to refuse to sign this form. If you refuse to sign this form, your information will not be shared as indicated on this form. Your refusal to sign this form will not affect your treatment, payment, enrollment or eligibility for benefits under your Plan.

You have a right to receive a copy of this authorization upon request.

If you do sign the form, you have the right to revoke this authorization at any time. You will need to do this by writing to Delta Health Systems at the address on page one. Your request will be effective on the date we receive it. Protected health information disclosed pursuant to this authorization may be subject to re-disclosure. If you later revoke the authorization, we will not be able to stop any disclosures that may have already taken place.

You acknowledge there is a potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer be protected by 45 CFR Part 164.

I declare under penalty of perjury that the information on this form is true and correct.

Print name of plan participant	HealthCare ID #
Participant/Personal Rep. Signature	Date
Telephone number	

Note: if you are acting as the personal representative of a plan participant, please tell us your relationship to the participant:

You may be required to show us proof of your legal permission to act for the participant.

Any attempt to falsely gain access to protected health information is subject to legal penalties.

Should you have questions about this form, please contact Delta Health Systems at the toll-free number listed on your ID card.