Authorization for Use or Disclosure of Information for Enrollment

This authorization for use or disclosure of personal health information is being requested by Health Net to comply with the terms of federal HIPAA Privacy Rules. A copy of this form is as valid as the original.

THIS AUTHORIZATION FORM MUST BE COMPLETED IN ORDER TO ENABLE HEALTH NET TO UNDERWRITE YOUR COVERAGE. THE ENROLLMENT PROCESS CANNOT BE COMPLETED WITHOUT YOUR EXPRESS AUTHORIZATION WHICH IS MORE FULLY DESCRIBED BELOW. THIS FORM MUST BE SIGNED BY THE APPLICANT AND EACH ADULT FAMILY MEMBER APPLYING FOR COVERAGE (including dependents age 18 and over).

Applicant and Family Members Requesting Enrollment:

Applicant Name	Social Security Number:
Spouse Name	Social Security Number:
Dependent (age 18 or older)	Social Security Number:
Dependent (age 18 or older)	Social Security Number:

I, ______________________________, ____,
(applicant print name) **(spouse print name)**

_________________________________, ____,
(adult dependent print name) **(adult dependent print name)**

hereby authorize the use or disclosure of personal health information as described below. Additional adult dependents may be listed below.

As the (applicant) parent, I, (print name) ____________________, authorize the use or disclosure of personal health information about my minor dependent(s), age 17 and under, as described below:

__________________, ___________________________, ______________________________,
(print dependent'(s) name)
__________________, ___________________________, ______________________________.

1. Person(s) or group of persons authorized to disclose the information to Health Net include:
   - Any medical professional, hospital, or other healthcare facility, clinic, pharmacy, insurer or health benefit plan administrator, Medicare or Medicaid, or any other health care provider or health plan that has medical information about me or my dependent(s);

All references to "Health Net" herein include the affiliates and subsidiaries of Health Net, Inc. which underwrite or administer the coverage to which the Enrollment Application applies.

- Health care providers or health plans indicated in my application for coverage or on my dependents' applications for coverage, or identified by me during a health history interview in regard to myself or my dependent(s), or identified by me or my dependent(s) to my agent, or any other healthcare provider or health plan referred to in my medical records or my dependent(s) medical records.

2. I authorize the following person(s) or group of persons to receive the information disclosed by one of the persons or organizations listed in paragraph 1 above, and to use that information and the information included on my application for coverage to underwrite and rate the health plan coverage for which I have applied:
   - Health Net and its affiliates including, but not limited to, its agents, underwriting operations, claims operations, legal representatives, its Medical Director or his/her designees, and its sales and marketing operations. I understand that Health Net may condition my or my dependents' enrollment in the health plan on my **signing this Authorization and initialing this paragraph 2**.

   Applicant ____ Spouse ____ Dependent ____ Dependent ____

3. Description of the information that may be used or disclosed includes:
   All health information pertaining to me or my minor dependent(s), if applicable, related to the diagnosis, treatment or prognosis with respect to any physical, accident, illness, medical or mental condition, including but not limited to, alcohol abuse, substance abuse, mental or emotional disorders, AIDS (Acquired Immune Deficiency Syndrome), or ARC (AIDS-Related Complex), <u>except</u> psychotherapy notes, and any other related information, including but not limited to, the information provided on my application.

4. I understand that if this Authorization is for disclosures to someone other than Health Net, personal health information disclosed may be subject to re-disclosure by the recipient, in which case it would no longer be protected by federal Privacy Rules. However, Health Net is subject to federal Privacy Rules and any information Health Net receives is protected by these Rules.

5. I understand that my enrollment in Health Net's health plan may be conditioned on my signing this Authorization and initialing paragraph 2. I understand that I may refuse to initial paragraph 2 of this Authorization, and that such refusal could affect my enrollment in the health plan or eligibility for benefits under the health plan.

6. If the person completing this Authorization is the personal representative of the applicant or dependent, describe your authority to act on this person's behalf.

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All references to "Health Net" herein include the affiliates and subsidiaries of Health Net, Inc. which underwrite or administer the coverage to which the Enrollment Application applies.

7. As described in the "Notice of Privacy Practices", I understand that I may revoke this Authorization in writing at any time, except to the extent that action has been taken by Health Net and it's subsidiaries and affiliates in reliance on this Authorization. I may send a written and dated revocation to Health Net to: Health Net Privacy Office, 21650 Oxnard Street, Ste. 2125, Woodland Hills, CA 91367. Health Net's "Notice of Privacy Practices" is available on the Health Net website at www.healthnet.com or will be provided to me in writing upon request.

8. I understand that either I am, or my personal representative is, entitled to receive a copy of my signed Authorization and by my signature below, I acknowledge that I have been provided with a copy.

9. This authorization will remain valid for thirty (30) months from the date the authorization form is signed as to Health Net's determination on enrollment.

Signatures ***(required in ink)***

APPLICANT'S SIGNATURE	Date Signed
SPOUSE'S SIGNATURE	Date Signed
SIGNATURE OF APPLICANT'S DEPENDENT (age 18 or older)	Date Signed
SIGNATURE OF APPLICANT'S DEPENDENT (age 18 or older)	Date Signed
PERSONAL REPRESENTATIVE'S NAME, IF APPLICABLE (Print)	
PERSONAL REPRESENTATIVE'S SIGNATURE	Date Signed

Please return this form to:
Health Net Individual & Family Plans
PO Box 1150
Rancho Cordova, CA 95741-1150

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