Gold Coast Health Plan℠
A Public Entity

Integrity • Accountability • Collaboration • Trust • Respect

MEMBER AUTHORIZATION FORM

This form is to be filled out if there is a request to release the member's protected health information to another person or company by Gold Coast Health Plan (GCHP).
Failure to provide all the information requested may invalidate this authorization.

PART A: MEMBER INFORMATION

Member First Name:	Member Last Name:		Middle Initial:
Member Address:	City:	State:	Zip Code:
Telephone Number:	Member ID Number (see ID Card):		Date of Birth:

PART B: PERSON OR COMPANY WHO WILL RECEIVE THE INFORMATION

The following people or companies have the right to receive my protected health information. Please check each box that applies and enter the identifying information.

☐ My spouse or domestic partner (enter first and last name)	☐ My adult children (enter first and last name[s])
☐ My parents (if you are 18 or older, enter first and last name[s])	☐ Other (Primary contact name [if you have it], name of company, and relationship to you)

PART C: PURPOSE OF THIS APPROVAL

The following people or companies have the right to receive my protected health information. Please check each box that applies and enter the identifying information.

☐ This release of information is being made at my request.

OR

☐ This release of information is being made for the reason(s) described below:

_____

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PART D: LIMITATIONS ON THE DISCLOSURE OF MY MEDICAL INFORMATION

I allow the following protected health information to be disclosed by GCHP on my behalf (check only one box):

☐ **All of my protected health information.** There are no specific limitations on the use of my information by the person or entity who will receive it. **This doesn't include sensitive information (see below) unless approved below.**

OR

☐ **Only the following limited information may be released** (check boxes below that apply to the limited information to release or disclose).

☐ Appeal	☐ Health Care Provider Info
☐ Benefits and Coverage	☐ Pharmacy
☐ Claims and Payment	☐ Pre-Authorization
☐ Diagnosis and Treatment	☐ Other:
☐ Eligibility and Enrollment	

I also approve the release of the following types of sensitive medical information by GCHP (check all boxes that apply):

☐ **All sensitive medical information (see list of sensitive medical information below)** _____ **(initial)**

OR

☐ **Only information regarding the sensitive information initialed below**

☐ Abortion	_____ (initial)	☐ HIV or AIDS	_____ (initial)
☐ Abuse	_____ (initial)	☐ Maternity	_____ (initial)
☐ Alcohol / Substance Abuse	_____ (initial)	☐ Mental Health	_____ (initial)
☐ Genetic Testing	_____ (initial)	☐ Sexually Transmitted Illness	_____ (initial)

PART E: DATE YOUR APPROVAL EXPIRES

If this document was not already withdrawn, this authorization will end on the earliest of the following dates:

☐ One year from the signature date in Part F below.

OR

☐ Earlier than one year and based upon the date, event, or condition described below:

_____

PART F: MEMBER APPROVAL

I have read the contents of this form. I understand, agree, and allow GCHP to use and disclose my health information as I have stated above. I also understand that I am signing this form of my own free will. I understand that GCHP does not require that I sign this form in order for me to receive treatment, payment, or for enrollment, or be eligible for benefits. I understand that I have the right to receive a copy of this authorization form.

I understand that I have the right to revoke this authorization at any time by giving written notice of my withdrawal to GCHP. I understand that withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be further used or disclosed by the person or group who receives it. If this happens, it may no longer be protected.

Signature of Member or Legal Representative: **X**	Date:

LEGAL REPRESENTATIVE / GUARDIAN

If this form is signed by someone other than the member or parent of member, such as a personal representative, legal representative or guardian on behalf of the member, please submit documentation of legal representation with this form (if not on file with GCHP) and complete the information below.

Legal Representative Name:	Legal Relationship to Member:
Legal Representative Signature: **X**	Date:

Please return the completed form to:

Gold Coast Health Plan
ATTN: Member Services Department
711 East Daily Drive, Suite 106, Camarillo, CA 93010-6082