Authorization to Use and Disclose Health Information

NOTICE TO MEMBER:

- When you complete this form, it allows CalViva Health (i) to use your health information for a certain purpose. It also allows CalViva Health to (ii) share your health information with the person or entity that you name on this form.
- This approval is required for the use or disclosure of your PHI beyond uses and disclosures for:
  - Payment
  - Treatment
  - Health care operations

It also complies with the terms of federal HIPAA rule 45 C.F.R. 164.508.

- You do not have to sign this form or give consent to use or share your health information. Your services and benefits with CalViva Health will not change if you do not sign this form.
- Right to cancel (revoke): This approval/consent form can be cancelled at any time. This is true except to the extent that CalViva Health, or other lawful holder of your health information that is allowed to share it, has already acted on your consent. If you want to cancel this Authorization Form, fill out the Revocation Form and mail it to the address at the bottom of the page.
- CalViva Health cannot promise that the person or group you allow us to share your health information with will not share it with someone else.
- Keep a copy of all forms that you send to us. We can send you copies if you need them.
- Fill in all the information on this form. When you have finished, mail it to the address at the bottom of page 3.

Member information

Member name (print):	
Member date of birth: / /	Member ID number:

I GIVE CALVIVA HEALTH CONSENT TO USE MY HEALTH INFORMATION FOR THE PURPOSE NAMED. AND, I GIVE MY CONSENT TO SHARE MY HEALTH INFORMATION WITH THE PERSON OR GROUP NAMED BELOW. THE PURPOSE OF THE APPROVAL IS TO:

☐ **Allow CalViva Health to help me with my benefits and services.**
☐ **Permit CalViva Health to use or share my health information for _____.**

Person or group to receive information (add additional persons or groups on page 2)

Name (person or group):			
Address:			
City:	State:	ZIP:	Phone:

(continued)

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I give my consent for CalViva Health to use or share the health information stated below:

☐ **All of my health information THIS INCLUDES:**

- Genetic information, services or tests
- Gender affirming care
- Sexual transmitted infections (includes HIV/AIDS data and records)
- Substance use disorder (related alcohol/prescription drug data)
- Behavioral and mental health data and records (excludes psychotherapy notes)
- Reproductive and sexual health data (includes all family planning and pregnancy-linked services)

Or,

☐ **All of my health information EXCEPT (check all boxes that apply):**

☐ Genetic information, services or tests

☐ Gender affirming care

☐ Sexual transmitted infections (includes HIV/AIDS data and records)

☐ Substance use disorder (linked alcohol/ prescription drug data)

☐ Behavioral and mental health data and records (excludes psychotherapy notes)

☐ Reproductive and sexual health data (includes all family planning and pregnancy-linked services)

☐ Other: _____

Expiration of authorization

This approval will end on / / (mm/dd/yy). It will be valid for one-year only. If no date is given, it will expire one year from the date below.

Member signature (member or legal representative sign here):	Date: / /

If you are signing for the member, describe how you know the member below. If you are the member's Personal Representative, describe this below. And, send us copies of those forms (e.g. Power of Attorney or Order of Guardianship).

_____

Other person(s) or entity(ies) to receive information

Note: If you are consenting to disclose any substance use disorder records to a person or place that is neither a:

- Third party payor
- Health care provider
- Facility
- Program where you receive services from a treating provider (e.g. health insurance exchange or research institute), known hereafter as a "recipient entity"

You must specify the name of the person with whom, or the entity at which, you receive services from a treating provider at that recipient entity. Or, simply state that your substance use disorder records may be disclosed to your current and future treating providers at that recipient entity.

(continued)

Name (person or group):			
Address:			
City:	State:	ZIP:	Phone:

Name (person or group):			
Address:			
City:	State:	ZIP:	Phone:

Name (person or group):			
Address:			
City:	State:	ZIP:	Phone:

Mail finished form to:
CalViva Health Eligibility Department
P.O. Box 10420, Van Nuys, CA 91499-6208
Phone: 888-893-1569
Fax: 844-222-3180