Health Net of the Northeast, Inc.
One Far Mill Crossing
Post Office Box 904
Shelton, Connecticut 06484-0944

www.healthnet.com

Health Net
Authorization for Disclosure of Health Information

(1) I hereby authorize Health Net to disclose the following information from the health records of

Member Name ________________________________ Date of Birth_______________
Address ________________________________ Telephone _______________
________________________________ Member ID# _______________

covering the period(s) of healthcare

From(date)______________________________
To(date)__________________________

From(date)______________________________
To(date)__________________________

(2) Information to be disclosed

- ☐ complete health record(s)
- ☐ history & physical examination
- ☐ claim information
- ☐ benefit information
- ☐ discharge summary
- ☐ progress notes
- ☐ laboratory tests
- ☐ other

(please specify)____

Check if disclosure shall include information relating to:

- ☐ Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection
- ☐ Behavioral health services/psychiatric care
- ☐ Treatment for alcohol and/or drug abuse

If boxes are not checked, no such information shall be released.

(3) This information is to be disclosed to__________________________________for the purpose of ____.

(4) Unless otherwise revoked, this authorization shall become effective immediately and shall remain in effect until (date) ______________., event, condition:_________________________
month/day/year

(5) I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization.

NE37802 (4/07) 6013332

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(6) Additional Copy. I understand that I have a right to receive a copy of this authorization upon my request

Copy requested and received: Yes_____ No_____ ___________
Member initial

(7) Health Net, its employees and officers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

(8) Information used or disclosed pursuant to an authorization may be subject to redisclosure by the recipient and no longer protected by the federal health information privacy regulations.

(9) Neither payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. This restriction does not apply if Health Net is seeking to obtain information in connection with my eligibility or enrollment in Health Net when I am not already a member or to obtain information required for payment of a specific claim for benefits.

Signed:

____
Member Date

____
or Legal Representative Relationship to Member Date

____
Signature of Witness Relationship to Member Date

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