AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the use and/or disclosure of individually identifiable health information, as set forth below, consistent with California and Federal laws concerning the privacy of such information. **Failure to provide ALL information requested may invalidate this authorization.**

YOUR RIGHTS

• I may refuse to sign this authorization, which invalidates this authorization.

• I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the Physician Network entity to which I originally submitted the authorization.

• My revocation will be effective upon receipt, but will not be effective to information disclosed prior to the date of revocation.

• I have a right to receive a copy of this authorization.

• John Muir Physician Network may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization, except:
  • For research related treatment.
  • When the authorization is for eligibility/enrollment/underwriting/risk rating determination.
  • When the sole purpose for creating the requested protected health information is to disclose to a third party.
I hereby authorize the use or disclosure of my health information as follows:

Name and address of persons/organizations authorized to disclose the information:

☐ John Muir Physician Network
   P.O. Box 5107
   Walnut Creek, CA 94596

☐ Other: __________________________

1. I authorize the following person(s)/organizations to receive my health information (include address):

2. This authorization applies to: (Please Check all that apply)
   ☐ Only the following records or types of health information or specific dates of treatment
   ☐ Status on Claims and Processing   ☐ Enrollment and Eligibility Inquiries

   Specific dates of treatment____________________

   ☐ Status of Authorizations   ☐ Other _________________________

   Specific dates of treatment____________________

   ☐ All health information pertaining to any medical history, mental or physical condition and
treatment received. Includes information related to drug, alcohol and/or psychiatric
conditions, or conditions pertaining to sexually transmitted diseases, including AIDS. HIV
test result information will NOT be released unless specifically requested.

   List specific dates of treatment needed for use/disclosure:____________________

Exclusions:______________________________________________________________

3. The receiver may use the medical information for the following purposes only:

California law prohibits the receiver from making further disclosure of my health information
unless the receiver obtains another authorization from me or unless such disclosure is
specifically required or permitted by law.

4. This authorization expires: (date)________________. If blank, authorization will expire 1
year from date of signature.

Signature of person giving permission for release of their Health Information:

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<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Signature</th>
<th>Day Time Phone</th>
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Member Name:__________________________ Mail form to:
DOB:__________________________ Attention: Customer Service
Health Plan:__________________________ P.O. Box 5107
Health Plan ID #:__________________________ Walnut Creek, CA 94596