

Southern California Drug Benefit Fund PHI Authorization Form

If you want the Plan to give any of your Protected Health Information (PHI) to another person or entity, please complete this Authorization and submit as instructed below. Please refer to the Plan's Privacy Notice for a description of PHI.

1. Your name: _____ 2. Your birth date: _____

3. Covered Participant's name: _____

4. Covered Participant's Social Security Number: _____

5. Describe the specific PHI that you authorize the Plan to use or disclose. For example, describe the (i) health records you authorize the Plan to disclose by date(s) of service, and/or name of doctor(s) or other health care provider(s); (ii) your eligibility information; (iii) information related to your appeal from a claim denial: _____

6. If this authorization is at your request, you may initial here _____ to state that the purpose is "At the request of the individual." Otherwise, describe the specific purpose of the disclosure: _____

7. Provide the name and contact information for each person or entity to whom the above described PHI may be disclosed. Attach additional sheets if necessary.

| | | | |
|-----------------------|------------------|-----------------------|------------------|
| Name of Person/Entity | Telephone Number | Name of Person/Entity | Telephone Number |
| Street | | Street | |
| City | State | City | State |
| Zip Code | | Zip Code | |

8. Initial here _____ if you authorize the Plan to speak with the person(s) named in section 7 about the PHI described in section 5 above.

9. This Authorization will expire _____ [insert expiration date or event relating to you personally]; otherwise, this Authorization will remain in effect for one year or until revoked by you in writing, whichever is earlier.

Read and sign the following statement:

I authorize the Plan to use and disclose my PHI as described above. I understand that: 1) PHI disclosed in accordance with this Authorization may be re-disclosed by the recipients listed in this Authorization and, as a result, may no longer be protected under applicable health privacy laws or under the Plan's privacy practices. 2) Payment of my Plan claims and eligibility for my Plan benefits are not affected by my decision to complete this authorization. 3) This Authorization is valid until the revocation date indicated above, or until I revoke it in writing. I understand that I have the right to revoke this Authorization at any time, except to the extent that the Plan has already used or disclosed my PHI in reliance on this authorization.

Signature*: _____ Date: _____

*If you are making this request on behalf of another individual, a completed Personal Representative form must be on file with the Plan unless the individual is your minor child or ward and you also participate in the Plan.

This completed Authorization must be received by the Plan at: Privacy Officer, Southern California Drug Benefit Fund, 2220 Hyperion Avenue, Los Angeles, CA 90027. Fax: (323) 663-9495.

If you have questions about this Authorization form, contact the Plan at (323) 666-8910, x201.

For internal use only:

Date received: _____ Date revoked: _____