WESTERN GROWERS

Instructions for Completing the Authorization Form

SECTION A: Individual authorizing use and/or disclosure.

List the information of the person who is authorizing the use and/or disclosure of Protected Health Information (PHI).

SECTION B: The use and/or disclosure being authorized.

1. Specify what PHI you are allowing to be used and/or disclosed. Example: Billings from providers of health services, current insurance eligibility, etc.

   - If this authorization is for psychotherapy notes please check the box on form. This will apply only to the psychotherapy notes. If you would like any other information to be provided that does not apply to psychotherapy notes, a separate form must be submitted.

2. List the names of all entities/persons you are authorizing that we may disclose information to.

3. List names of all entities/persons including us who are authorized to receive and then subsequently use and/or disclose PHI.

4. Check the appropriate box indicating the reason why the authorization is being sent in. At your request or for a specific purpose. If it is for a specific purpose, list the purpose.

SECTION C: Expiration and revocation.

1. Check the appropriate box indicating when you want this authorization to expire; on a specific date, or, if this is only for a certain event. **Example:** Claims incurred for an accident. All authorizations have a maximum lifetime of 24 months from the date of signature.

2. Clearly print the name(s) of **each** person that is age 18 and over that is authorizing information to be disclosed. Each person must also sign and date the form.

Western Growers

P.O. 7240, Newport Beach, CA 92658
(800) 777-7898 Fax: (949) 809-8952

AUTHORIZATION FORM
TO RELEASE PROTECTED HEALTH INFORMATION

SECTION A: Individual authorizing use and/or disclosure.

Name: _____

Address: _____

Telephone: _____ Employee Identification Number: _____

SECTION B: The use and/or disclosure being authorized.

Protected Health Information (PHI) to Be Used and/or Disclosed: **{Specifically describe the PHI to be used and/or disclosed}**

_____

_____

☐ Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, you must *not* use it as an authorization for any other type of PHI.

Entities or Persons Authorized to Use or Disclose: **{Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), including us, who are authorized to make use of and/or to disclose the PHI described above}**

_____ _____

_____ _____

Entities or Persons Authorized to Receive: **{Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations), including us, who are authorized to receive, and subsequently use and/or disclose the PHI described above}**

_____ _____

_____ _____

Purpose of this Authorization:

☐ At request of individual.

☐ For the following purposes:

_____

_____

No Conditions: This authorization is voluntary. We will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization.

Effect of Granting this Authorization: The PHI used or disclosed may be subject to re-disclosure by the recipient, in which case it may no longer be protected under the HIPAA Privacy Rule.

SECTION C: Expiration and revocation.

Expiration: This authorization will expire (complete one):

☐ On _____/_____/_____

☐ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):

_____

_____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: Western Growers

Fax: (949) 260-6629
Address: P.O. 7240, Newport Beach, CA 92658

INDIVIDUAL'S SIGNATURE.

I, _____, have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information, as described in this form.

Print Name: _____

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Signature: _____ Date: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.