Physicians Network Medical Group, Inc.

Benefits Administration

Post Office Box 619031
Roseville, CA 95661-9031
800-441-2524
AdventistHealth.org

Benefits Administration

General Disclosure Authorization, Designation of Personal Representation, and/or Email Consent

I hereby authorize the PNMG Provider Health Plans (referred to as the "Plans," which include the PPO and High Deductible plans) to use and disclose my protected health information as detailed in this form.

Member's Name (Please Print): _____

Member's Health plan ID: _____ Date of Birth: _____

Phone Number: _____ Best Day/Time to Call: _____

Please complete the applicable sections (ALL ARE OPTIONAL):

☐ **GENERAL AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION** – *allowing others to receive/use your information*

_____ [insert name(s) of individual(s) or company(ies)] are authorized to receive and use the following health information (please print):

_____

[Please include a specific description of the information to be used and disclosed to the above-named recipient(s), including relevant dates and conditions (for example, health information related to treatment received in May 2014 for injuries from car accident). If you want the recipient(s) to be able to receive and use all of your health information, then write "All of my health information."]

The purpose for the disclosure is:

_____

[Please describe the purpose for the disclosure or, if there is not a specific purpose, write "At my request and for no specific purpose."]

Expiration Date: _____ Please write either a date or, if you intend for the authorization(s) to be ongoing, please mark the box below.

☐ Expiration upon the earlier of the Plans' receipt of written revocation; or the occurrence of both (1) payment or finalized denial of all of my claims under the Plans, and (2) my termination of enrollment in the Plans.

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☐ **DESIGNATION OF PERSONAL REPRESENTATION** – *allowing others to receive/use your information and to speak and/or make decisions on your behalf with respect to claims/appeals with the Plans. (This is not an advance health care directive or power of attorney and does not authorize your representative to make medical decisions for you.)*

I hereby designate the below Authorized Representative(s) to act as my personal representative(s) and to speak and/or make decisions on my behalf with respect to claims/appeals with the Plans:

Name of Authorized Representative (Please print): _____

Relationship to Member: _____Phone: _____

Name of Authorized Representative (Please print): _____

Relationship to Member: _____Phone: _____

My Authorized Representative(s) are authorized to receive and use the following health information:

_____

[Please include a specific description of the information to be used and disclosed to your Authorized Representative(s), including relevant dates and conditions (for example, health information related to lung cancer diagnosis and treatment from December 2012 to February 2013). If you want your Authorized Representative(s) to be able to receive and use all of your health information, then write "All of my health information."]

The purpose for the disclosure is:

_____

[Please describe the purpose for the disclosure or, if there is not a specific purpose, write "At my request and for no specific purpose."]

Expiration Date: _____ Please write either a date or, if you intend for the authorization(s) to be ongoing, please mark the box below.

☐ Expiration upon the earlier of the Plans' receipt of written revocation; or the occurrence of both (1) payment or finalized denial of all of my claims under the Plans, and (2) my termination of enrollment in the Plans.

☐ **EMAIL CONSENT:**

☐ I agree to be contacted by Email. Email communication from your Plans is secured by company encryption standards.

Member's approved email address(s): _____

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Important Information About Your Rights

- The Plans will not receive any financial or in-kind compensation or remuneration in exchange for using or disclosing the health information described above.
- This authorization is voluntary and I may refuse to sign it.
- I may revoke this authorization at any time prior to its expiration date by sending a written revocation notice to the Plans' Benefits Administration office at the address below. The revocation will not have any effect on any actions that the Plans took before receipt of the revocation notice.
- I am not required to sign this authorization as a condition to receiving treatment or payment for health care, enrolling in the Plans, or establishing eligibility for benefits.
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving person or organization and, upon redisclosure, may no longer be protected by federal privacy laws.

Member Signature: _____ Date: _____

If this form is signed by a personal representative, complete the following information:

Printed name of the member's personal representative: _____

Relationship to the member, including authority to act as personal representative (for example, parent, legal guardian, advance care directive, or power of attorney specifying health care): _____

_____

Please return this form to the Plans' Benefits Administration office by fax or mail.

Fax number: 916-406-1780

Mail to:

Benefits Administration
P.O. Box 619031
Roseville, CA 95661