Health Net of the Northeast, Inc.
One Far Mill Crossing
P.O. Box 904
Shelton, CT 06484-0944

www.health.net

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)
- ☐ discharge summary
- ☐ history & physical examination
- ☐ progress notes
- ☐ claim information
- ☐ laboratory tests
- ☐ benefit information
- ☐ 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.

(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.

Signed: ____
Member Date

____
or Legal Representative Relationship to Member Date

____
Signature of Witness Relationship to Member Date