

**DIRECTORS GUILD OF AMERICA – PRODUCER
HEALTH PLAN**
8436 W. Third Street, Suite 900
Los Angeles, CA 90048-4189
(323) 866-2200 ext. 401 (877) 866-2200 toll-free outside Los Angeles area



INSTRUCTION SHEET

For Completing the Authorization for Release of Health Information Form

The attached form is required for release of Protected Health Information (“PHI”) in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

1. The “Individual” is the person who is authorizing the release of his or her protected health information. The “Participant” is the insured person.

*****Important*****

The Plan is required to have a separate form for each Individual age 18 or over that is signed by that Individual. Forms submitted on behalf of an Individual that is 18 or over that are not signed by that Individual are invalid.

2. **SECTION A**

Give a description of the health and/or eligibility information that you are allowing the Health Plan to disclose on your behalf. You may be as general or as specific as you choose.

Example of a general description

All health claims and all health eligibility information

Example of a specific description

Information regarding my surgery on December 3, 1999

3. **SECTION B**

Give the full name of the person or organization to whom you are allowing the Health Plan to release your health information. Please do not fill in your relationship to the person or organization. Instead, please specifically name the person or organization.

Examples

John Smith

California Management, Inc.

4. **SECTION C**

State the purpose for which the Health Plan is allowed to release health information to the person or organization named in SECTION B.

Examples

To assist with my healthcare

At the request of the individual

5. **SECTION D**

Specify when the authorization will expire. Please specify an expiration date or event. Once your authorization expires, the Health Plan will require a new Authorization for Release of Health Information before releasing any of your Protected Health Information on your behalf.

Example of an expiration date

12/31/06

Example of an expiration upon occurrence of an event

Termination of participation in Plan

6. **PLEASE NOTE:** *It is very important that you complete Sections A, B, C and D of the Authorization For Release of Health Information. The form will be invalid if A, B, or C are left blank or if the form is not signed. If you do not complete Section D, then your Authorization will remain in effect 1 year, or until it is revoked by you in writing, whichever is earlier.*

Please do not hesitate to call the Plan Office at the number listed at the top of the instruction sheet if you need any help completing the attached form.

DIRECTORS GUILD OF AMERICA - PRODUCER HEALTH PLAN
Authorization For Release of Health Information

I hereby authorize the Directors Guild of America-Producer Health Plan (the "Plan") to disclose certain individually identifiable health information (described in (A) below) to the persons in (B) below for the purposes described in (C) below.

Individual's Name: _____ Participant's Social Security Number: _____

Participant's Name (if other than the Individual listed above): _____

A. Specific description of information to be used or disclosed (including date(s), if applicable): _____

B. Persons/organizations authorized to receive the information: _____

C. Specific purpose of the disclosure: _____

(If you, the individual, are requesting the disclosure, and you don't want to describe your reasons, you may state "At the request of the individual.")

This authorization is not valid if you do not fully complete Section A, Section B and Section C.

D. This authorization will expire on: _____
Date or Event

(If you do not select an expiration date or event, your authorization will remain in effect 1 year or until revoked by you in writing, whichever is earlier.)

Important Information About Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the Plan in writing, but the revocation will not have any effect on any actions the Plan took before it received the revocation.
- I am entitled to a copy of this authorization.
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity without my authorization.
- I understand that I am not required to sign this form to receive my health care benefits, although I must complete all applicable forms for benefits.
- I understand that I may decline to sign this authorization. However, it will be invalid if not signed.

Signature of Individual or Individual's Personal Representative

Date

(Form MUST be completed before signing.)

Personal Representative (if applicable)

Print name of personal representative (person who has the legal status as personal representative of the individual, such as power of attorney for health matters or legal guardian. Attach copy of legal status): _____

Relationship to the individual, including authority for status as representative: _____

If you have any questions regarding this form, please contact the Health Plan Department:

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FAX (323) 866-2326 No Cover Sheet Needed