DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

This document authorizes the Department of Health Care Services to disclose and discuss health information about you or the person you represent with the Legislator and the member(s) of his or her staff assigned to assist with your problem. Unless otherwise indicated below, this authorization does not authorize the disclosure of HIV test results, mental health treatment information, or alcohol or drug treatment information. Treatment, payment, enrollment in a health plan, and eligibility for benefits will not be affected if you do not sign this authorization.

_____

Print Full Name of Beneficiary or Plan Member

OR

_____ on behalf of _____

Print Name of Representative *Print Name of Beneficiary or Plan Member*

authorizes the Department of Health Care Services to communicate with and disclose medical information you specify on this form to the office of:

_____

Print Name of Legislator

Briefly describe the problem that led you to contact your Legislator's Office?

California Department of Health Care Services
Legislative and Governmental Affairs
P.O. Box 997413 | Sacramento, CA | 95899-7413
Phone (916) 440-7500 | www.dhcs.ca.gov/Pages/LGA.aspx

State of California
Gavin Newsom, Governor
California Health and Human Services Agency

I specifically authorize the release of the following information (check and initial as appropriate):

☐ Mental health treatment information: (initial) _____

If you check either of the following boxes, you will be required to fill out a different form:

☐ HIV information: (initial) _____

☐ Alcohol/drug treatment information: (initial) _____

This authorization is in effect until the following date _____, or the resolution of the problem described above, after which this authorization expires.

I understand that by signing this authorization:

▲ I authorize the use and disclosure of the health information described on this form only for the purpose(s) stated.

▲ I have the right to receive a copy of this authorization.

▲ I have the right to revoke this authorization at any time by sending a written notice to the Department of Health Care Services, Office of Legislative and Governmental Affairs at the address listed at the bottom of the first page of this authorization.

▲ My revocation is effective upon receipt, except it does not apply to uses and disclosures before it takes effect.

▲ I understand that health information disclosed through the authorization is no longer protected and could be disclosed to another entity.

Please fill in the Beneficiary/Plan Member Information on the next page.

Beneficiary/Plan Member Information

Last Name		*First Name*	*Middle Initial*
Address		*City/State*	*Zip Code*
Benefits Id Number		*Email Address*	
Date Of Birth	*Date Of Death (if applicable)*	*Home Phone Number*	*Work Phone Number*

If you are the Representative of a Beneficiary or Plan Member, please fill in your information and provide a copy of the written legal authority showing that you are authorized to act on behalf of the beneficiary or plan member. If the beneficiary or plan member is deceased, please provide a copy of the death certificate.

_____ _____
Printed Name *Relationship to Beneficiary*

_____ _____
Address *E-mail*

_____ _____
City, State, Zip Code *Telephone Number*

Indicate Your Relationship – Please Attach Written Legal Authority

☐ *PARENT OF MINOR CHILD* ☐ *ATTORNEY AT LAW*

☐ *GUARDIAN* ☐ *CONSERVATOR* ☐ *EXECUTOR/ADMINISTRATOR*

☐ *HEATHCARE POWER OF ATTORNEY* ☐ *OTHER*_____

Please sign the authorization.

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

SIGNATURE _____ ***DATE*** _____