



INSURANCE ASSISTANCE SECTION CONSENT AND AUTHORIZATION FORM



Consent to Participate in Insurance Assistance Section (IAS) Program and Consent and Authorization for Use and Disclosure of Personal and Medical Information for Client Eligibility (For Transition from State Pre-Existing Condition Insurance Plan (PCIP) to Federal PCIP and then Medi-Cal, Covered California or other Plan.)

Your insurance coverage will be changing:

- The state's PCIP that you have been enrolled in will terminate and all individuals who have been enrolled in state's PCIP will be transitioned to the federal PCIP by July 1st, 2013. In order for the California Department of Public Health (CDPH) to assist you in making this transition, we need you to sign this form to authorize CDPH to discuss your personal information with the federal PCIP.
- The federal PCIP is temporary program that will expire at the end of 2013. Beginning January 1, 2014 you will need to transition to Medi-Cal or a new health insurance plan that is administered through Covered California or another entity. In order for CDPH to assist you in making the transition to Medi-Cal, Covered California or another entity, we need you to sign this form to authorize CDPH to discuss your personal information with Medi-Cal, Covered California or the other entity that will administer the plan you transition into.

To assist you and to verify eligibility for the IAS program and eligibility for these plans, and in order for CDPH to make monthly premium payments if you are eligible and are enrolled into the federal PCIP program and later into a successor program through Medi-Cal, Covered California or another entity, CDPH, or its agents may be required to obtain personal information from other agencies or health care providers. If you agree to take part in IAS, the enrolling agency will collect personal information including your name, date of birth, address, Social Security Number, medical history, and financial eligibility for the program. The information will be considered confidential, but may be released to CDPH, enrollment workers who provide services to you, the federal PCIP, the National Finance Center (the federal PCIP administrator), Covered California, Department of Health Care Services (DHCS), Consolidated Omnibus Budget Reconciliation Act (COBRA) administrators, health insurance companies, employers and employer administered health insurance plans, health care professionals who provide services to you, and other governmental or public agencies as necessary to determine your eligibility for these plans and for the purpose of administering the IAS program.

Information that you provide for your application may be made available to your local health department for statistical purposes. This information includes, but is not limited to, gender, ethnicity, zip code, diagnosis status, and date of birth. This information may also be used for professional writings under strict assurances that all identifying information including name and Social Security Number is deleted. Any professional or research reports that may be published will not use your name nor any personal identifying

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information.

CDPH will not be able to pay any premiums on your behalf if you do not sign this authorization. This means that if you do not sign this authorization, your eligibility for benefits will be affected.

I, _____, hereby consent to and authorize the release of personal and medical information as described above to CDPH, and by CDPH to enrollment workers who provide services to me, the federal PCIP, the National Finance Center, Covered California, DHCS, COBRA administrators, health insurance companies, employers and employer administered health insurance plans, health care professionals who provide services to me, and other governmental or public agencies as necessary to determine my eligibility for these plans, eligibility for IAS services, to administer the program, and for CDPH to make monthly premium payments if I am eligible and am enrolled into the federal PCIP program and later into a successor program through Covered California or another entity. This consent shall remain in effect for two years from the date of my signature below unless revoked by me in writing. A photocopy of this consent shall be considered as valid as the original.

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable personal information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time except if you have already acted because of my permission. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the personal information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

Signed by Individual:	Date
Or Signed by Personal Representative: _____	Date
On Behalf of: _____ <div style="text-align: center;">Name of Individual</div>	

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IDENTIFYING INFORMATION

COPY OF IDENTIFICATION ATTACHED

TYPE _____ (CA DRIVER'S LICENSE, CA DMV IDENTIFICATION CARD, BIRTH CERTIFICATE, BENEFITS IDENTIFICATION CARD, MANAGED CARE CARD, STATE OR FEDERAL EMPLOYEE ID CARD)

NUMBER _____

IF NO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED

NOTARIZED BY _____

ON _____ (DATE)

NOTARY PUBLIC NUMBER _____

NOT OFFICIAL UNLESS STAMPED BY NOTARY PUBLIC
(IF NO IDENTIFICATION IS ATTACHED)

WHAT LEGAL AUTHORITY DO YOU HAVE TO MAKE PERSONAL DECISIONS FOR THE INDIVIDUAL?

PARENT

CONSERVATOR

GUARDIAN

EXECUTOR OF WILL

MEDICAL POWER OF ATTORNEY OTHER

NOTE: ATTACHING LEGAL DOCUMENTATION IS REQUIRED TO VERIFY THAT YOU ARE THE PARENT, CONSERVATOR, GUARDIAN, EXECUTOR OF A DECEDENT'S WILL, OR HAVE PERSONAL DECISION-MAKING AUTHORITY FOR THE INDIVIDUAL.

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DEPARTMENT EMPLOYEE PROCESSING/MAINTAINING THIS AUTHORIZATION

_____ Richard Martin, Chief, IAS _____

(Name and title)

_____ IAS _____

(Organization within Department)

_____ 916.449.5974 _____

(Telephone Number)

_____ 7704 _____

(Mail Stop Number)

ENROLLMENT SITE CONTACT INFORMATION (IF APPLICABLE)

Enrollment Site Name:

Enrollment Worker Name:

Enrollment Site Address (Number, Street, Suite #)

City

State

Zip Code

Telephone Number

Fax Number

Email Address

PRIVACY STATEMENT (CA CIVIL CODE SECTION 1798.17)

THE INFORMATION COLLECTED ON THIS FORM IS USED TO GET YOUR PERMISSION FOR THE USE OR DISCLOSURE, TO NON-DEPARTMENT PERSONS/ORGANIZATIONS, OF CERTAIN PERSONAL INFORMATION ABOUT YOU MAINTAINED BY THE DEPARTMENT. THIS INFORMATION WILL BE KEPT CONFIDENTIAL AND ON FILE AT THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH, AS REQUIRED BY LAW. ALL INFORMATION REQUESTED ON THE FORM IS VOLUNTARY. NOT SUPPLYING THE INFORMATION REQUESTED WILL HAVE NO EFFECT ON YOU OR YOUR TREATMENT, PAYMENT, OR ELIGIBILITY FOR BENEFITS OR SERVICES FROM THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH. ANY INFORMATION PROVIDED MAY BE DISCLOSED TO THE CALIFORNIA STATE AUDITOR, THE CALIFORNIA OFFICE OF HEALTH INFORMATION INTEGRITY, THE CALIFORNIA OFFICE OF INFORMATION SECURITY AND PRIVACY PROTECTION, THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES OR TO OTHER STATE AND FEDERAL AGENCIES AS REQUIRED BY LAW.

YOU HAVE THE RIGHT TO REVIEW THE RECORDS WE KEEP ABOUT YOU DURING NORMAL BUSINESS HOURS. THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH PRIVACY OFFICER WILL, UPON REQUEST, INFORM YOU REGARDING THE LOCATION OF YOUR RECORDS AND THE CATEGORIES OF ANY PERSONS WHO USE THE INFORMATION IN THOSE RECORDS. FOR MORE INFORMATION, CONTACT THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH, PRIVACY OFFICE, USING THE FOLLOWING CONTACT INFORMATION: CALIFORNIA DEPARTMENT OF PUBLIC HEALTH, OFFICE OF LEGAL SERVICES, PRIVACY OFFICE, MS 0506, P.O. BOX 997377, SACRAMENTO, CALIFORNIA 95899-7377 OR BY PHONE 1-877-421-9634.