KERN LEGACY Network Plus
EXCLUSIVE NETWORK HEALTH PLAN

KERN LEGACY HEALTH PLANS

Employee & Retiree Medical Plan Options

KERN LEGACY Share Select
HIGH-DEDUCTIBLE EPO HEALTH PLAN

1115 TRUXTUN AVE, 1ST FLOOR | BAKERSFIELD CA 93301 | PH: 661 868-3280 | FAX: 661 868-3295 | WWW.KERNLEGACYHP.COM

Authorization for Use and/or Disclosure of Protected Health Information (PHI)

This form authorizes Kern Legacy Health Plans to use and/or disclose your PHI to the individuals that you have specified below. For the purpose of this form, PHI is considered as individually identifiable health information received or maintained by Kern Legacy Health Plans. Without a completed and signed authorization form, Federal law prohibits Kern Legacy Health Plans from releasing your PHI to your spouse, parents, adult children, other family members, or personal friends unless you are present at the time of disclosure.

SECTION A: Individual Authorizing Use and/or Disclosure

Member Name:					
Member ID:		***Date of Birth:***			
Address:					
City:		***State:***		***Zip:***	
Phone Number:		***Date of Request:***			

SECTION B: Security Code

Select a 4-digit numerical security code that will be used to assist Kern Legacy Health Plans in identifying the authorized person(s) listed in Section C when disclosing the information indicated in Section D. Please provide this 4-digit security code to the authorized person(s). Without this security code, Kern Legacy Health Plans will not disclose information to the authorized person(s).

4-Digit Security Code:	

SECTION C: Person(s) You Are Authorizing Kern Legacy Health Plans to release your PHI to

I authorize my Kern Legacy Health Plan to release information to:					
1) Name of Provider Organization or Person:					
Relationship to Member:					
Address:					
City:		***State:***		***Zip:***	
Phone Number:		***Fax:***			
2) Name of Provider Organization or Person:					
Relationship to Member:					
Address:					
City:		***State:***		***Zip:***	
Phone Number:		***Fax:***			
3) Name of Provider Organization or Person:					
Relationship to Member:					
Address:					
City:		***State:***		***Zip:***	
Phone Number:		***Fax:***			

SECTION D: Purpose of This Use and/or Disclosure *(check all boxes that apply)*

☐	Inquiries regarding authorizations for pharmacy and health care services
☐	Inquiries regarding claims, benefit coverage, and eligibility
☐	Discussions regarding assignment of benefits, direction of care, and plan of care
☐	Primary Care Provider (PCP) changes and member ID card replacements
☐	Pharmacy and medical member reimbursements
☐	Other (please specify):

SECTION E: I Understand That

- My right to healthcare is not conditioned on this authorization.
- I may cancel/revoke this authorization at any time by submitting a written request to Kern Legacy Health Plan, however; the cancelation will not have any effect on any actions that Kern Legacy Health Plan took prior to receiving the revocation.
- If the person or facility receiving this information is not a healthcare or medical insurance provider covered by the privacy regulations, the information stated above may be re-disclosed
- A recipient of medical information in California may not further disclose medical information about me (the member) unless a new authorization form is signed by me or my personal representative or unless the disclosure is specifically required or permitted by law.

SECTION F: Expiration and Right to Revoke

This authorization will expire. Choose an expiration date or give an expiration event that relates to the purpose of this release (i.e., when I retire; upon disenrollment of the plan). If a date or event is not entered, this authorization will automatically expire in one year from the date of the request.

Date of expiration:	
Expiration event:	

I understand that I may cancel/revoke this authorization at any time by giving written notice to Kern Legacy Health Plans. I can mail or drop off my notice of revocation to:

Kern Legacy Health Plans – Health Plan Services
1115 Truxtun Ave, 1st Floor
Bakersfield CA 93301

SECTION G: Signature of member or authorized representative

I, _____, have had full opportunity to read and consider the contents of this
Member Name
authorization.

I understand that by signing this form, I am confirming my authorization that is allowing Kern Legacy Health Plans to release the protected health information described in this form for the purposes stated in this form.

Member's Signature: _____ ***Date:*** _____

Signature of an authorized Representative (if applicable)

Authorized representative means you have legal proof that you are authorized to act for this person. An authorized representative signs for a plan member who may not legally sign on his or her own. If the member is less than 18 years old, a parent or guardian should sign for the minor. We must have the legal documentation of your appointment on file with this authorization form.

Authorized Representative's Signature: _____

Date: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT

For Office Use Only:	
Date Received (stamp):	Employee Initial:
Effective Date:	Expiration:

Print Clear Form